Blue Q Health & Wellness

UPDATE FORM

Name:_____ Date of Birth: _____ Today's Date:_____

(Please complete each entry if there was a change in information otherwise write *'SAME'*)

Address:_____ City/State/Zip:_____

Phone:_____ Email:_____

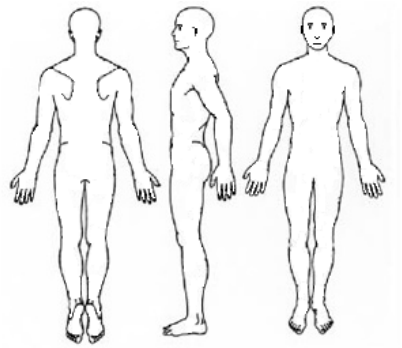
Primary Insurance:_____ (please give card and ID for file)

Secondary Insurance:_____ (please give card and ID for file)

Main Complaint/Reason for Visit: _____

_____

Area(s) of complaint (circle on diagram); Please describe in the blank space to the right of the diagram:



Stiffness Soreness Numbness Tingling Weakness Swelling Dull Achy Sharp Stabbing Burning

If you are experiencing pain, please circle a number: (No Pain) 0-1-2-3-4-5-6-7-8-9-10 (Severe)

When did your symptom(s) begin?_____

How often do symptoms occur? (Circle One) Occasional Intermittent Frequent Constant

Is the complaint getting: (Circle One) Better Worse Same/Not Changing N/A

What activities do you find difficult: _____

_____

_____

What makes the problem(s) better?_____

What makes the problem(s) worse?_____

Since we saw you last, was there a new accident/surgery/medication? If yes please explain:

_____

Have you treated elsewhere? Do you have a Family Physician________

Do we have your permission to contact them (Y or N) for coordination of care? _____

2480 E. Bay Dr. #13, Largo, FL 33771
727-530-7778

***REVIEW OF SYMPTOMS*: Which of the following conditions do you now have or have you previously had?** (circle)

Arthritis	Asthma	Sinus Issues	Blood Clots	Allergies	
Tuberculosis		Diabetes	Vertigo	ADD/ADHD	Epilepsy
Migraine/HA's		Thyroid	High/Low BP	Heart Trouble	
Pacemaker		HIV/AIDS	Cancer	Polio	Scoliosis
Mental/Emotional		Prostate Trouble	Hormonal	Dislocation	
Disc Herniation/Bulge		Rheumatic Fever	Bone Fracture	Osteoporosis	
Kidney Disease		Digestive Trouble	Acid Reflux	Sleep Disorder	**NONE**

Family History, any new information: _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I understand that my health information will remain private and will not be shared with anyone without my written or verbal approval. I have received a copy of Blue Q Health and Wellness PLLC Notice of Privacy Practices. I understand that Blue Q Health and Wellness PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Blue Q Health and Wellness PLLC at any time to obtain a current copy of the Notice of Privacy Practices. I authorize the sharing of my health information with the following party or parties listed below **(ex. a family member, lawyer, or another health provider office who may request your records or need to discuss care – please list name and/or organization below on the line provided)**:

_____

Client Signature_____ Date _____

I hereby request and consent to the performance of massage therapy, or Neurosomatic Therapy on me (or on the client named below for whom I am legally responsible) by the licensed massage therapist named below and any of the soft tissue therapist located at Blue Q Health and Wellness. I have had an opportunity to discuss with the licensed practitioner below and/or with other office or clinic personnel the nature and purpose of the therapy and other procedures. I understand that results are not guaranteed. I understand and am informed that in the practice of soft tissue therapy there are some risks to treatment, including but not limited to bruising and emboli. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely upon the practitioner to exercise judgment during the course of the procedure which they feel at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Client Signature_____ Date _____

LMT Signature _____ Date_____

Blue Q Health and Wellness Policies

Cancellations and Missed Appointment Policy

Appointments canceled same day or missed (no call/no show) will incur either a **$30 charge, the full service amount, or count toward the service package**. All appointments must be canceled or rescheduled by the close of the day prior (7:00pm the day before) in order to avoid the charge or package deduction.

I acknowledge and understand the policy and have been given a copy for my records (if requested).

_____ _____

Signature Date