Blue Q Health & Wellness

Name:_____ Today's Date:_____

Address:_____ City/State/Zip:_____

Insurance:_____ Date of birth: _____

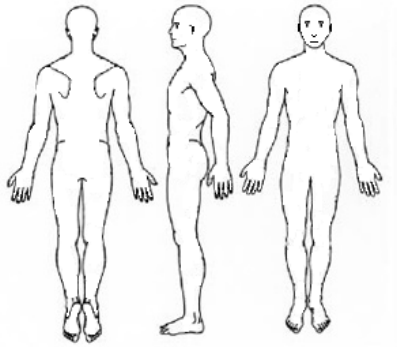
Phone:_____ Email:_____

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

Affected Activities of Daily Living: _____

_____

_____

What makes the problem(s) better?_____

What makes the problem(s) worse?_____

Medical History:

Have you treated elsewhere for this condition? N or Y (Date of last visit: _____)

Name/Location/ Phone: _____

Do you have a Family Physician: N or Y (Do we have your permission to contact them: Y or N)

Name/Location: _____

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727-530-7778

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Have you been hospitalized last 5 yrs? N or Y **(explain)** _____

Have you had Surgery last 5 yrs? N or Y **(explain)** _____

Have you had a serious Accident/Injury last 5 yrs? N or Y **(explain)** _____

Do you have any Allergies? N or Y **(list)** _____

Are you currently taking any Medication? N or Y **(list)**_____

WOMEN ONLY:
Are you currently pregnant? Y or N (Yes, due date: _____)
Date of Last Physical Exam: _____ Where? _____

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

Arthritis	Asthma	Sinus Issues	Blood Clotts	Allergies
Tuberculosis	Diabetes	Vertigo	ADD/ADHD	Epilepsy
Migraine/HA's	Thyroid	High BP	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

Family History:

	Cancer	Diabetes	Blood Pressure	Heart Attack	Stroke	Osteoporosis	Arthritis	Scoliosis	Other
Father									
Mother									
Sibling (s)									
Child/Children									
Grandparent(s)									

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:

_____

(List any names of lawyers, doctors, or family members who may contact us for your health information)

_____ _____
Patient Name (or Guardian) Date

_____ _____
Representative of Blue Q Health and Wellness Date

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SOFT TISSUE THERAPY INFORMATION:

Name: _____ Today's Date: _____

Have you had a professional massage before? Y or N

What type of massage are you seeking? Relaxation Deep Tissue _____

What pressure do you prefer? Light Medium Heavy

Are you sensitive to any fragrances or have a skin allergy to oils? Y or N

Are there any areas that you do not want treated? Y or N

Please circle any of the following that are true for you:

Cancer (current)	Blood Clots or Deep Vein Thrombosis (current or past)	
Stroke	Burns or Open wounds (current)	
Rheumatoid Arthritis	Chemo or Radiation treatment (current)	
Recent Surgery	Broken Bones or Fracture (current)	
Pregnant (current)	Automobile Accident (current)	**None apply to me**

Are you taking any medication? Y or N

What are your goals for this treatment session?

_____

_____

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_____

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QUESTIONS PERTAINING TO MASSAGE AND OUR SOFT TISSUE THERAPIES:

- It is OK if you would like treatment with the door open (just ask)
- It is OK if you would like treatment with clothing on (we may not be able to reach all areas but would rather you be comfortable)
  - Our mini massage (15 min) is clothing on typically 1-2 regions and done either sitting up at the massage chair or lying down on a table.
  - Our 30 min to 120 min sessions are typically done on the massage table with dress to your comfort but draping with the table linens is required and bottom undergarment left on. Some people prefer to wear a bathing suit or workout ware. Please ask if you have any questions.

During the massage:

- It is OK if you would like less pressure or more pressure during the session (you won't hurt our feelings)
- It is OK if you would like us to move on from a particular area or spend more time focusing on a particular region
- It is OK if you would like us to alter our technique

After the massage:

- Please be careful getting up quickly (some people experience temporary light headedness or dizziness)
- Be sure to hydrate by drinking water
- If sore use ice or other topical analgesics (it is not uncommon for the body to process the effects of the massage for up to 72hrs)
- If you have any questions, don't hesitate to call our office and speak with one of our therapists

We hope that you <u>enjoy</u> your treatment, <u>feel AMAZING</u> after, <u>rebook</u> with us, and <u>tell others</u>!

*If there is anything else that we can do here at blue Q Health and Wellness to make your treatment even better, please let our front desk know :)

Card on File Policy

In an effort to expedite the checkout process and to help with weekend and after hour appointments, we will require a credit or debit card on file (square card processing system). Other forms of payment will still be accepted at checkout. The card on file can/will be used for the following: balances due, payment for services completed, appointment cancellations same day ($30 fee), no call/no shows missed appointments (full fee), packages, insurance copayments, etc. An electronic notification will be sent by email or text when payment is processed. If notification preferences change, please notify us by phone or at the front desk.

I authorize Blue Q Health and Wellness to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

(Circle one of the following)

Amex **Visa** **MasterCard** **Discover**

Last 4 digits of your Card Number: _____

Cardholder Name: _____

Zip Code: _____

Email/Phone number you would like receipt sent to: _____

I (we), the undersigned, authorize and request Blue Q Health and Wellness, LLC to charge my card on file, indicated above, for balances due for services rendered. This authorization relates to all payments not covered by my insurance company or any fees associated with missed and same day cancellations. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30 day notification to Blue Q Health and Wellness and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ Date:_____