Quiet Spring
A Place for Healing and Wellness
P.O. Box 1124
Safety Harbor, FL 34695
(727)797-0874 MM29399

Contact Info

Personal information is never shared with or sold to anyone. Information on your medical condition is only shared with other health professionals with your permission.

*First Name*________________________________ *MI*________

*Last Name*_________________________________

*Address*____*Apt#*_______________

*City*________________________________ *State*________________ *Zip*_____________

*Email address*____

*Date of Birth*______________________ *Age*________ *Sex:* *M*____ *F*_____

Married _____ *Widowed* ______ *Single* _______ *Separated* _____ *Divorced* ______

We call to confirm appointments and to follow up after treatment. Please choose how you would like to be contacted by phone.

When is the best time and number to reach you? ______________________________

Alternate phone. ____

In the event of an emergency, whom shall we contact?
*Name*____

*Relationship*__________________________________

*Phone(s)*_____________________________________

Basic Health History

Have you ever received a Professional Massage or Bodywork?
No____ Yes____ When was the last time? ______________

Why did you come for our service?
Stress Reduction___ Pain ___Injury___ Therapy____
Other________________________

What are the results that you would like to achieve? ______________________________

____

What body area is the priority? ____

Areas you wish ***not*** *to be massaged____*

Are you under a doctor's care for any reason?
____

Primary Care Physician Info:
Physician's Name ____

Address ____

Phone Number ______________________

Medications Vitamins/ Herbs/Minerals/Supplements

________________________________ *for* ______________________________________
________________________________ *for* ______________________________________
________________________________ *for* ______________________________________
________________________________ *for* ______________________________________

Allergies (Please note any scents or oils!)

___

___

How you move or don't move your body gives us insight in how to help you.

Exercise Level

How often?

None____ 2x month____ weekly_____ 2x a week_____ 3x a week_____ Daily_____

What level?

Light______ Moderate______ Heavy______

What Kinds of activity?

Aerobics______ Weight Training_______ Stretching/Yoga_______

Work activity

Sitting______ Standing_______ Light Labor_______ Heavy Labor________

Lifestyle Options

Smoking______ packs/day______ Coffee/Caffeine_______ cups/day________

Alcohol_______ drinks/week_____ High Stress Level___ Reason__________

If Female Are you Pregnant?
No____ Yes_____ Due Date? ____________________

Conditions

Please check any you have now. If in the past, please include the year.

Anemia *Year:*	Fractures *Year:*	Pacemaker *Year:*
Anorexia *Year:*	Glaucoma *Year:*	Pinched Nerve *Year:*
Appendicitis *Year:*	Head Injuries *Year:*	Pneumonia *Year:*
Arthritis *Year:*	Heart Disease *Year:*	Polio *Year:*
Asthma *Year:*	Hepatitis *Year:*	Prosthesis *Year:*
Blood Clots *Year:*	Hernia *Year:*	Rheumatoid Arthritis *Year:*
Breathing Difficulty *Year:*	Herniated Disk *Year:*	Rheumatic Fever *Year:*
Bursitis *Year:*	Herpes *Year:*	Sinus Problems *Year:*
Bronchitis *Year:*	High Blood Pressure *Year:*	Stroke *Year:*
Bulimia *Year:*	HIV/AIDS *Year:*	Tendonitis *Year:*
Cancer *Year:*	Jaw Pain/TMJ *Year:*	Thrombosis *Year:*
Chemical Dependency *Year:*	Lymph edema *Year:*	Thyroid Problems *Year:*
Concussion *Year:*	Migraines *Year:*	Tuberculosis *Year:*
Diabetes *Year:*	Mononucleosis *Year:*	Tumors *Year:*
Emphysema *Year:*	MS *Year:*	Ulcers *Year:*
Epilepsy *Year:*	Osteoporosis *Year:*	Varicose Veins *Year:*
Fibromyalgia *Year:*	Parkinson's *Year:*	Whiplash *Year:*

Liability Waiver

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my health care provider if I ever have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe or treat any physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion.

Office Policies

I understand payment is due at time of service.

I understand my treatment time begins at my scheduled appointment time and ends 30, 60 or 90 minutes later, depending on the amount of time reserved.

If we are unable to begin on time due to lateness on my account, I will receive only the time left in the session and I will be responsible for full payment.

If we are unable to begin on time due to the therapists timing. I will receive the full time or I will be offered extra time to be scheduled later at a time of my choosing.

I understand that while the therapy I receive is a personal service, it is NEVER a sexual service.

I understand that my appointment time is especially reserved for me. To avoid paying for a missed appointment, I understand it is my responsibility to give at least 24-hour notice of cancellation.

Patients Signature *Date*

Guardian or Parent Signature *Date*