# The Oasis

A Healing Spa for the Body, Mind, and Soul.
318 S. Scenic Hwy.
Suite # 105
Lake Wales, FL 33853
(863) 232-6968
MM#20448

Name:_____ D.O.B:_____ Sex: Female__ Male__
Address:_____ City:_____ State:_____ Zip_____
Telephone #: Home(___)_____ Cell(___)_____
Employer:_____Occupation:_____
Work #: (___)_____ E-Mail Address:_____
In Case of Emergency, Please Notify: Name:_____
Relationship:_____ Telephone:_____
Would you like to receive our coupons and special offers by mail or e-mail: Yes__ No__
Please let us know how you heard about us:_____

**Please take a moment to carefully read and fill out the following information. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to receiving therapy.**

Have you ever received a professional massage or bodywork before: Yes__No__
If yes, when was your last therapy:_____
What results would you like to achieve with today's session:_____
_____

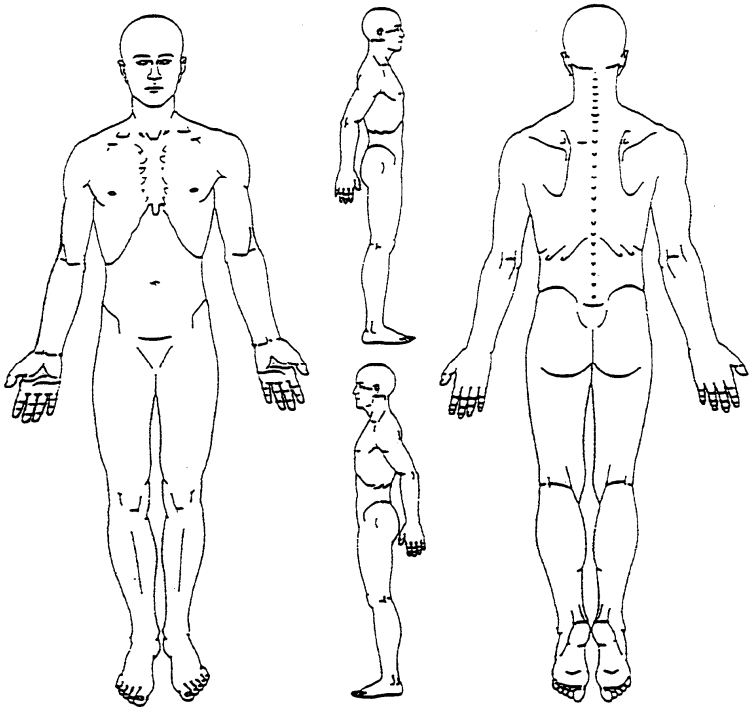
**Please list any of the following conditions or symptoms that you may have or suffer from:**

Yes__ No__ Do you frequently suffer from stress?
Yes__ No__ Do you have Diabetes?
Yes__ No__ Do you experience frequent headaches?
Yes__ No__ Are you pregnant?
Yes__ No__ Do you suffer from arthritis?
Yes__ No__ Are you wearing contact lenses?
Yes__ No__ Are you wearing dentures?
Yes__ No__ Do you have high blood pressure?
If yes, is your blood pressure regulated with medication?
Yes__ No__
Yes__ No__ Do you suffer from epilepsy or seizures?
Yes__ No__ Do you suffer from joint swelling?
Yes__ No__ Do you have any contagious diseases?
Yes__ No__ Do you have osteoporosis?
Yes__ No__ Do you have any allergies?
If yes, please list:_____

Yes__ No__ Do you bruise easily?
Yes__ No__ Any injuries in the past two years?
If yes, please explain:_____
Yes__ No__ Any broken bones in the past two years?
If yes, where:_____
Yes__ No__ Do you have cardiac or circulatory problems?
Yes__ No__ Are you ticklish, sensitive to touch or pressure?
If yes, please list area(s):_____
Yes__ No__ Have you ever had surgery?
If yes, please explain:_____

Please use the area below to list any other medical conditions, or any medications I should know about:
_____
_____
_____

Please use the figure below to shade in any areas where you are feeling pain or discomfort:



I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any physical or mental ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature_____ Date _____

Practitioner Signature _____ Date _____

**Consent to Treatment of Minor:** By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

**Signature of ParentorGuardian_____Date_____**

# Privacy Statement

All patient records and Patient/Client information is protected by applicable Florida State & Federal medical privacy laws. Every Patient/Client is hereby advised that Florida State & Federal laws protect the privacy and confidentiality of their records and no information about them or their medical records will be released without their specific written consent and authorization. In the event that a Patient/Client has created a power of attorney, that document must be produced in its' original form before release of medical records can occur. No Patient/Client records will be transmitted electronically as the method does not assure complete privacy or control of medical records. When information is released on the authority and consent designated by the Patient/Client, that person must sign for it before the United States Postal Service will surrender it to them.

This is for your protection. You are welcome to discuss with me any questions you may have now or in the future, Erika B. Schindler, LMT.

Patient Signature _____ Date _____

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# Privacy Statement

# Maintenance of Patient Records

All Patient/Client records will be maintained in a locked file cabinet in a locked office at the massage establishment. No person other than the therapist caring for the Patient/Client shall have access to Patient/Client records. It is strictly forbidden for any therapist or employee of Erika B. Schindler, LMT to discuss with anyone or release any information in the Patient/Client record without specific written permission from the Patient/Client. Neither will there be any discussion of the Patient/Client information with any other staff member or other individuals except as it applies directly to the care of the Patient/Client to which the Patient/Client has given written permission.

A Patient/Client may make changes to their record as allowed by Florida State Law and under the following conditions:

1. The change does not violate Florida State Law or Federal Law
2. The information provided is not being used to evade prosecution, defraud, defame or misrepresent
3. The information is true, accurate and factual

What cannot be changed is the information acquired through direct observation, such as injury or signs of trauma on the Patient/Client at the time of the service, nor can false statements be documented with regard to therapist assessment and/or exam of the Patient/Client.

Patient Signature _____ Date _____

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