New Client Health History

PRINT Name:_____ Date: _____

Address:_____City, State, Zip:_____

Birthdate:_____ Phone (Cell):_____ (Home):_____

Email Address:_____ (will not be shared)

How did you hear us? Client Referral (name)_____ Drove By_____ Google/Internet_____

Yelp_____ Received as Gift_____ Other:_____

Occupation:_____ Height:_____ Weight:_____

Emergency Contact:_____ Phone:_____ Relationship_____

Have you ever received massage therapy?_____ If Yes, what frequency:_____

What type of pressure do you prefer? Light ____ Moderate ____ Moderate/Deep_____ Deep _____ Not Sure_____

What results do you want from your massage?_____

Are you under the care of a physician or have any diagnosed conditions?_____

Please explain:_____

List medications you currently take:_____

_____

List any recent surgeries or injuries:_____

Please indicate any muscle problems and/or areas of chronic, tight muscles:_____

_____

Are you pregnant?_____ If yes, how many weeks?_____

Please indicate any conditions that you are currently experiencing, or have in the past:

____ Heart Condition/High Blood Pressure
____ Vericose /Spider Veins
____ Blood Clots/Phlebitis
____ Cancer or Tumors
____ Asthma/Bronchitis/Respiratory Conditions
____ Ulcers or other digestive problems
____ Immune system function conditions
____ Fibromyalgia
____ Psychological Disorders/ Anxiety
____ Allergy Symptoms
____ Excessive Fatigue
____ Back / Spinal Problems / Sciatica
____ Osteoporosis/Broken, Fractured Bones
____ Arthritis: Rheumatoid / Osteo
____ Bursitis / Tendonitis / Sprains
____ Diabetes
____ Numbness/Tingling/Nerve Degeneration/ Loss of Sensory Perception
____ Kidney/Urinary Problems
____ Hepatitis A, B, or C
____ Headaches/Migraines
____ Seizures
____ Athlete's Foot / Skin Infections / Warts
____ Abdominal / Pelvic Conditions

_____ **(INITIAL)** Being that massage is contraindicated (should not be done) under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully. I agree to keep the massage therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.

_____ **(INITIAL)** This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment for the scheduled treatment.

_____ **(INITIAL)** I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

_____ **(INITIAL)** Cancellation/Late Arrival Policy: If I arrive late, I understand my session may be shortened and will be charged the full amount of my scheduled session. I agree to give 24 hours advance notice if I need to cancel or reschedule my appointment. **If less than 24 hours notice is given, I will be expected to pay for my appointment IN FULL, and/or forfeit the service from an existing package or gift certificate.**

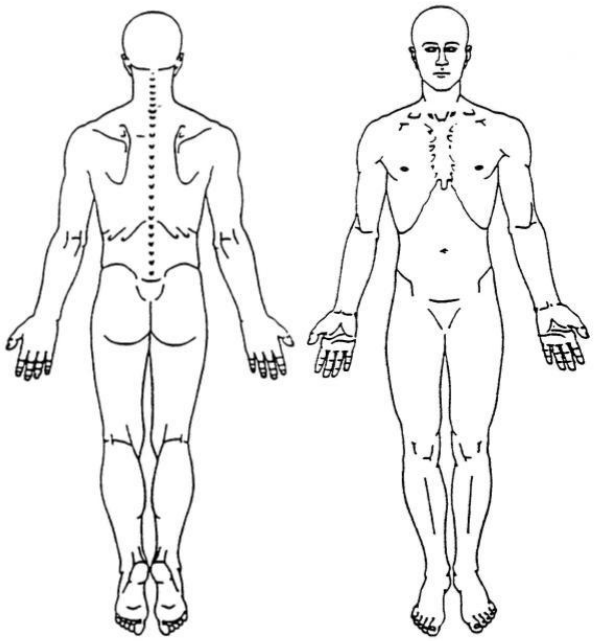
_____ **(INITIAL)** I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19.

BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS AT HALFMOON MASSAGE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: _____ Date: _____

(Below is for office use only)

Date:_____ Session:_____ LMT:_____

S		
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