

Client Confidential Health History

Name: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ Birthday: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
You will be added to our mailing list. We will never sell your email address to a third party. We value your privacy.  
How did you hear about Halfmoon Massage? \_\_\_\_\_

Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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? \_\_\_\_\_

Do you currently have a cold, flu, fever, areas of infection or inflammation? \_\_\_\_\_

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, for how long? \_\_\_\_\_ Are you wearing dentures? \_\_\_\_\_

(continued on back)----

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

- Heart Condition/High Blood Pressure
- Varicose /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

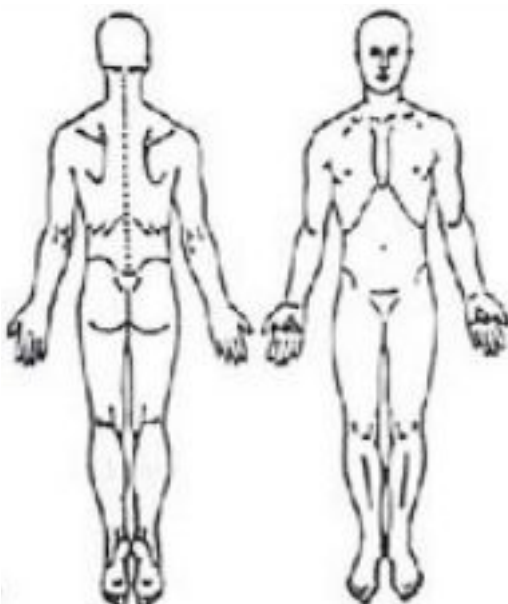
Please read the following information and sign below:

- 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.
- 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.
- 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.
- **Cancellation/Late Arrival Policy: I agree to provide at least 24 hours advance notice if I need to cancel an appointment, otherwise I will pay a \$30 cancellation fee. If I arrive late, I understand my session may be shortened and will be charged the full amount of my scheduled session.**

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Below is for office use)

Date: \_\_\_\_\_ Length of Session: \_\_\_\_\_ LMT: \_\_\_\_\_

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<b>O</b>		
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