PATIENT INFORMATION FORM

Welcome to Blue Moon Pilates. In order to provide you with the best treatment possible, please take a moment to complete this form. Thank You.

Patient Name _____ Date _____

Address _____ City _____ State _____

Zip Code _____ Date Of Birth _____

Telephone (Work) _____ (Home) _____

(Cell) _____ Email _____

In Case Of Emergency Notify _____ Telephone _____

Do You Have Any Of The Following (CHECK ALL THAT APPLY)

- o Headaches
- o Stress
- o Diabetes
- o Are you pregnant?
- o Arthritis
- o High Blood Pressure
- o Epilepsy or Seizures
- o Joint Swelling
- o Do you have any contagious diseases?
- o Osteoporosis
- o Allergies
- o Broken Bones
- o Accident or Injuries
- o Cardiac or Circulatory Problems
- o Numbness or Stabbing Pains anywhere?
- o Fibromyalgia
- o Gout
- o Emphysema
- o Polio
- o Shortness of Breath
- o Blackouts
- o Visual Disturbances
- o Ringing in Ears
- o Bowel and Bladder Problems
- o Stroke
- o Sleeping Disorders

If you checked any of the conditions above, please provide dates and circumstances

_____

_____

_____

_____

Are you currently taking any medications? o Yes o No IF YES, PLEASE LIST

_____

_____

_____

_____

Have you received massage/physical therapy or any alternative health care before? o Yes o No

Have you ever had a motor vehicle accident, fall, injury or surgery (including dental surgery)?
o Yes o No IF YES, PLEASE PROCIDE PERTINENT DATES AND CIRCUMSTANCES

_____
_____
_____
_____

Do you exercise regularly? o Yes o No IF YES, PLEASE DESCRIBE

_____
_____
_____
_____

Any other medical conditions or additional comments regarding your health

_____
_____
_____
_____

I have been informed that my treatments may consist of a variety of therapeutic modalities, including but not limited to Myofascial Release, Cranio-Sacral Therapy and Movement Therapy (comprised of Pilates, Yoga and Myofascial Stretching).

I understand that Blue Moon Pilates does not diagnose or treat any illness, disease or other medical or mental disorder. I also understand that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I affirm that i have disclosed all of my known medical conditions and answered all questions to the best of my knowledge. I acknowledge that it is my duty to keep Blue Moon Pilates updated as to any changes to the information I have provided in this form.

I authorize Blue Moon Pilates and Judy Richardson, RMT, CPI, to administer the above described treatments as deemed necessary by Blue Moon Pilates.

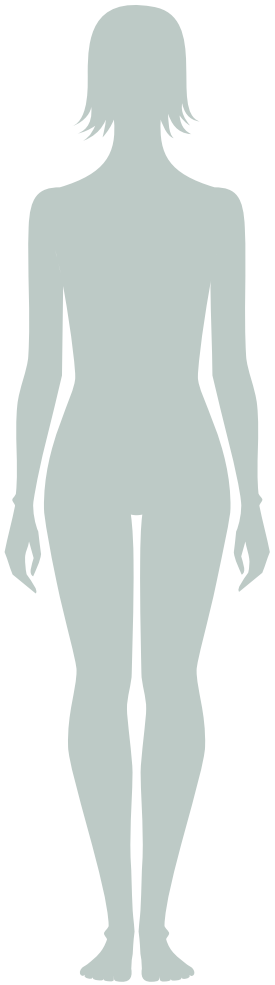
Blue Moon Pilates

By _____
Judy Richardson
RMT, CPI

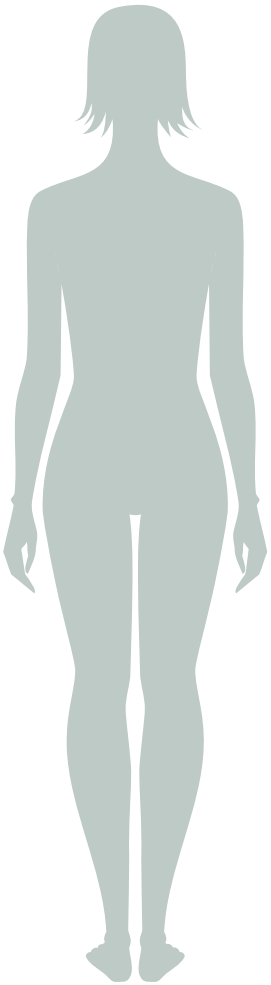
_____
Patient Signature

Patient Name _____

PLEASE INDICATE ON THE DIAGRAM ANY SPECIFIC AREA OF PAIN, SORNESS OR SENSITVITY



FRONT



BACK

LEFT SIDE

RIGHT SIDE