BLUE MOON BODY
PATIENT INFORMATION FORM

Welcome to Blue Moon Body. 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 Phone: _____ Email: _____

In case of emergency notify: _____ Telephone: _____

Do have any of the following:

☐ Yes	☐ No	Headaches?	☐ Yes	☐ No	Numbness or Stabbing Pains anywhere?
☐ Yes	☐ No	Stress?	☐ Yes	☐ No	Fibromyalgia?
☐ Yes	☐ No	Diabetes?	☐ Yes	☐ No	Gout?
☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No	Emphysema?
☐ Yes	☐ No	Arthritis?	☐ Yes	☐ No	Polio?
☐ Yes	☐ No	High Blood Pressure?	☐ Yes	☐ No	Shortness of Breath?
☐ Yes	☐ No	Epilepsy or Seizures?	☐ Yes	☐ No	Blackouts?
☐ Yes	☐ No	Joint Swelling?	☐ Yes	☐ No	Visual Disturbances?
☐ Yes	☐ No	Do you have any contagious diseases?	☐ Yes	☐ No	Ringing in Ears?
☐ Yes	☐ No	Osteoporosis?	☐ Yes	☐ No	Bowel and Bladder Problems?
☐ Yes	☐ No	Allergies?	☐ Yes	☐ No	Stroke?
☐ Yes	☐ No	Broken Bones	☐ Yes	☐ No	Sleeping Disorders?
☐ Yes	☐ No	Accident or Injuries?			
☐ Yes	☐ No	Cardiac or Circulatory Problems?			

If you answered "yes" to any of the above conditions, please provide dates and circumstances:

_____

_____

_____

_____

Are you currently taking any medications? ☐ Yes ☐ No If "yes," please list: _____

_____

_____

Have you received massage therapy, physical therapy, or any alternative health care before?

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☐ Yes ☐ No

Have you ever had a motor vehicle accident, fall, injury, or surgery (including dental surgery)? If "yes," please furnish the pertinent dates and circumstances:_____

Do you exercise regularly? 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 Body 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 Body updated as to any changes to the information I have provided in this form.

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

BLUE MOON BODY

By:_____
Judy Anderson
RMT, CPI

_____
Patient Signature