Holistic Abdominal Therapy

Female Teen

Personal Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Parent(s)/Guardian(s): _____

Address: _____

City / State / Zip: _____

Phone: _____

Referred by: _____

Reason for Visit

What are your intentions/expectations for this visit and what are your major complaints or conditions you want to improve? _____

_____

_____

_____

When did you first notice major complaints? _____

_____

What brought it on? _____

Has there been a medical diagnosis? _____

Massage

Have you had massage/bodywork before? _____ What Type? _____

What kind of pressure are you comfortable with? _____

Medical History

List any medications/supplements your are taking and reason for taking them:

_____

_____

Do you have any other medical/health concerns or conditions?

_____

_____

Please list any accidents, traumas: _____

Injuries to head, sacrum, tailbone: _____

Surgical History: _____

_____

Reproductive Health History

What age did you begin your menses? _____

What was the first day of your last period? _____

How often do your periods come? _____ How long do they last? _____

Episodes of Amenorrhea? _____ When? _____ For how long? _____

Do you have any concerns about your menstrual cycle? _____

Please check as appropriate:

Menstrual & Ovulatory Symptoms		**Hormonal Imbalance**	
Painful Periods		Headaches or Migraines with period	
Painful Ovulation		PMS / Depression / Irritability	
Dark Blood at beginning or end of cycle		**Bladder Issues**	
Clotting		Chronic Bladder Infections	
Excessive Bleeding		Frequent urination	
Spotting		Chronic Nocturnal Urination	
Low Back Pain with period		Difficult/Painful or Incomplete Urination	
Bloating / Water Retention		**Pelvic Floor Stagnation**	
Heaviness in Pelvis with period		Pelvic Pain	
Irregular Menstrual Cycles		Pain in Genital Area	
Digestive Issues		Rectal Pain	
Chronic Constipation		Sluggish Digestion	
Pain with Bowel Movements		Unexplained Low Back Pain	
Straining		Recurrent Vaginal Infections	
Other Digestive Issues		Ovarian Cysts	

Digestion and Elimination

Best thing you do with your diet: _____

Worst thing in your diet: _____

Food allergies or sensitivities: _____

How many glasses of water do you drink a day? _____

How often do you have a bowel a movement? _____

Constipation? _____ Loose stools? _____ Other concerns?_____

Please take a moment to carefully read the following information and sign where indicated. 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 service being provided.

I understand that if I experience any pain or discomfort during any 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/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, 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, and/or treat any physical or mental illness, and that nothing said in the course of any 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 of my known medical conditions, and answered all questions accurately, completely, and honestly.

I agree to keep the massage/bodywork 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 forget to do so.

I understand that I am having this massage at my own risk and hereby release Michelle Hansen and/or Moon Shadow Healing Arts from any liability.

Parent/Guardian Signature: _____ **Date:** _____