Holistic Abdominal Therapy

Female

Name: _____ Date: _____

Address: _____

City / State / Zip: _____

Phone: _____

Occupation: _____ Date of Birth: _____ Age: _____

Referred by: _____

Emergency Contact: Name / Relationship / Phone:

_____

What is the reason for your visit / what conditions do you want to improve? When did you first notice this? Is there something that triggers it?

_____

_____

_____

_____

Has there been a medical diagnosis? _____

By whom? _____

Massage

Have you had massage/bodywork before? _____

What Type? _____

What kind of pressure are you comfortable with? _____

Any other areas of tension outside of abdominal therapy you would like addressed?

Medical History

Medications/supplements you're taking and reason for taking them:

_____

_____

Do you have any other medical/health concerns?

_____

_____

Accidents, traumas: _____

Injuries to head, sacrum, tailbone: _____

Surgical History: _____

_____

Pelvic Floor Stagnation and/or Hormonal Imbalance		**Fertility**	
Painful Intercourse		Infertility / Fertility Issues	
Pelvic Pain		Polycystic Ovarian Syndrome (PCOS)	
Pain in Genital Area		Endometriosis	
Low Libido		Chronic Miscarriage	
Vaginal Dryness		**Circulatory System**	
Ovarian Cysts		Varicose Veins	
Recurrent Vaginal Infections		Hemorrhoids	
Uterine Fibroids		Restless Legs	
Uterine Infections		Cold hands and/or feet	
Uterine / Cervical Polyps		Edema / Swollen Feet or Ankles	
Musculoskeletal		**Other**	
Adhesions / Scar Tissue		Chronic Indigestion or Heartburn	
Uterine Prolapse		Vaginal Discharge	
		Womb Trauma:	

Reproductive Health

Are you using any methods for family planning / birth control? _____

What type? _____ Length of time using method? _____

What was the first day of your last menstrual period? _____

If they have stopped, when? _____

How often do your periods come? _____

How long do they last? _____

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

Menstrual & Ovulatory Symptoms		Clotting	
Pain or Discomfort with Menstruation		Spotting	
Irregular Menstrual Cycles		Low Back Pain with Period	
Absent Menstruation		Bloating	
Pain or Discomfort with Ovulation		Excessive Bleeding	
Irregular Ovulation		Heaviness in Pelvis with Period	
Lack of Ovulation		PMS:	
Bleeding or Spotting During Ovulation		Headaches or Migraines with Period	
Premature Ovarian Failure		Hot Flashes	
Dark Blood			

Peri-Menopause / Menopause		Mood Swings / Irritability	
Hot Flashes		Poor memory	
Irregular Menstruation		Increased libido	
Spotting		Decreased libido	
Flooding		Painful Interocourse	
Vaginal discharge		Other:	

Assisted Reproductive Technology

Are you under treatment for Infertility? _____

Describe current treatment: (I.V.F, I.U.I etc) _____

_____

Describe past treatments: _____

_____

Pregnancy

Are you pregnant or trying to conceive? _____

How many pregnancies have you had? _____ Number of Deliveries: _____

Terminations / When? _____ Miscarriages / When? _____

Complications: _____

Deliveries:

Birth Date	Childs Name	Gender	Complications

Diet, Digestion & 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? _____

Digestive Issues		**Bladder Issues**	
Abdominal pain		Frequent Urination	
Chronic Constipation		Nocturnal Urination	
Sluggish Digestion		Difficult Urination	
Straining		Painful Urination	
Pain with Bowel Movements		Incomplete Urination	
Rectal Pain		Chronic Bladder Infections	
Loose Stools		Incontinence	
Bloating after eating		Constant leakage	
Flatulence after eating		Bladder prolapse	
Other Digestive Issues			

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.

Client Name (printed): _____

Client Signature: _____ Date: _____

Please continue on to the next page if you are scheduled for a vaginal/yoni steam bath

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, vaginal/yoni steam baths may be contraindicated.

When Yoni steams should be avoided:

- If you are pregnant or there is a possibility of pregnancy.
- During or after ovulation if you are trying to conceive
- During menstruation
- With any open wounds, sores, blisters or stitches
- If you have a vaginal infection or fever or are prone to yeast infections
- Please do not steam if you are prone to bacterial/yeast infections.
- Piercings will need to be removed

I understand that if I experience any pain or discomfort during any session, I will immediately inform the practitioner so that the temperature may be adjusted to my level of comfort. I agree if the steam is too hot I will discontinue treatment immediately and notify my practitioner.

I further understand that vaginal/yoni steam baths 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 the practitioner facilitating the vaginal/yoni steam bath is not qualified to 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 vaginal/yoni steam baths 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 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 vaginal/yoni steam bath at my own risk and hereby release Michelle Hansen and/or Moon Shadow Healing Arts from any liability.

Client Name (printed): _____

Client Signature: _____ Date: _____