Holistic Abdominal Therapy

Female

email to moonshadowhealingarts@gmail.com

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

youImage 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 |
| --- | --- | --- | --- |
|  |  |  |  |
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|  |  |  |  |
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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**