**** The Arvigo Techniques of Maya Abdominal Therapy®

For Women

email to moonshadowhealingarts@gmail.com

Name: Date:

Address:

City / State / Zip:

Phone: E-mail:

Occupation: Date of Birth: Age:

Referred by:

Emergency Contact: Name / Relationship / Phone:

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?

By whom?

|  |  |  |  |
| --- | --- | --- | --- |
| Menstrual & Ovulatory Symptoms |  | Bladder Issues |  |
| Painful Periods |  | Frequent Urination |  |
| Painful Ovulation |  | Nocturnal Urination |  |
| Failure to Ovulate |  | Difficult/Painful or Incomplete Urination |  |
| Dark Blood at beginning or end of cycle |  | Chronic Bladder Infections |  |
| Clotting |  | Incontinence |  |
| Low Back Pain with period |  | Digestive Issues |  |
| Bloating / Water Retention |  | Chronic Constipation |  |
| Excessive Bleeding |  | Pain with Bowel Movements |  |
| Heaviness in Pelvis with period |  | Straining |  |
| Irregular Menstrual Cycles |  | Chronic Indigestion or Heartburn |  |
| Irregular Ovulation |  | Other Digestive Issues |  |
| Spotting |  | Pelvic Floor Stagnation |  |
| Hormonal Imbalance |  | Painful Intercourse |  |
| PMS / Depression / Irritability  |  | Pelvic Pain |  |
| Headaches or Migraines with period |  | Pain in Genital Area |  |
| Hot Flashes |  | Low Libido |  |
| Fertility |  | Sluggish Digestion |  |
| Infertility / Fertility Issues |  | Rectal Pain |  |
| Polycystic Ovarian Syndrome (PCOS) |  | Ovarian Cysts |  |
| Endometriosis |  | Recurrent Vaginal Infections |  |
| Chronic Miscarriage |  | Uterine Fibroids |  |
| Musculoskeletal Symptoms |  | Uterine Infections |  |
| Pelvic Floor Stagnation |  | Uterine Polyps |  |
| Adhesions / Scar Tissue |  | Unexplained Low Back Pain |  |
| Uterine Prolapse |  | Vaginal Dryness |  |
| Circulatory System |  | Other |  |
| Varicose Veins |  | Cancer - esp of the reproductive area |  |
| Hemorrhoids |  | Vaginal Discharge |  |
| Restless Legs |  | Womb Trauma |  |
| Edema in legs |  |  |  |

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

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 was the first day of your last period? If they have stopped, when?

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

Episodes of Amenorrhea? When? For how long?

A.R.T.

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:

| Birth Date | Childs Name  | Gender  | Complications  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Family Planning / Birth Control

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

What type?

Length of time using method?

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.

Client Name (printed):

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Please continue 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: \_\_\_\_\_\_\_\_\_\_\_\_