The Arvigo Techniques of Maya Abdominal Therapy®

For Women

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? _____

Please check as appropriate:

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

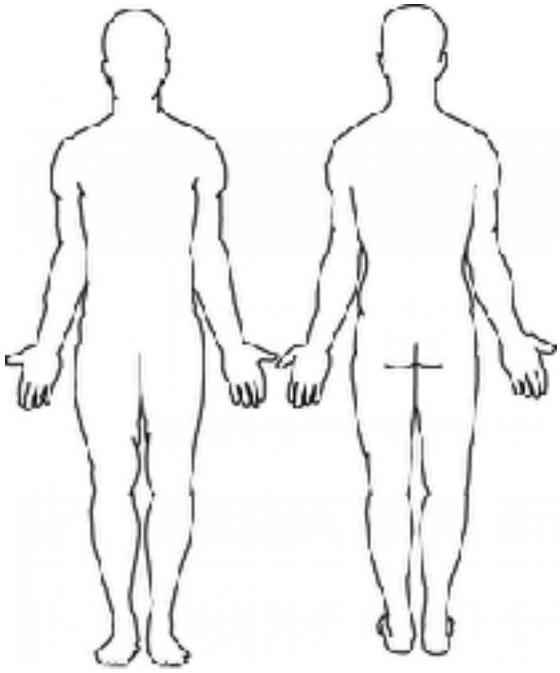
Have you had massage/bodywork before? _____ What Type? _____

What kind of pressure are you comfortable with? _____

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

_____

Please note affected body areas on the diagram with an "X"



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: _____

Deliveries:

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 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:** _____