**** 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When did you first notice major complaints? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical History

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

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Please note affected body areas on the diagram with an “X”

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

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Please list any accidents, traumas: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Injuries to head, sacrum, tailbone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe past treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_