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## Maya Abdominal Massage Client Information

Name:_____ Tel. No. (h): _____(w):_____(c):_____
Email:_____Address:_____ Apt:____ City:_____
State: _____Zip Code:_____ DOB:___/___/___ Age:_____ Sex: _____ Ht: _____Wt:_____
Marital Status: _____ No. of Children:_____
Occupation:_____ Employer: _____
Primary Physician: _____Physician Phone: _____
Emergency Contact Name:_____ Phone:_____ Relationship to You:_____
How did you hear about us?/Referred by: _____
Would you like to receive emails about specials and classes from Element Natural Healing Arts ? □ Yes No

### Medical History

Current medicinals/ supplements:_____
Previous surgeries:_____
Have you ever been advised to have a surgery that was not done? _____
Have you ever been hospitalized? If so, explain:_____
Allergic to any medications? _____Other known allergies? _____

### Present History

Current Weight_____ Weight One Year Ago_____ Weight Three Years Ago_____
Do you smoke cigarettes? (Please circle) Never/Seldom/Rarely/Sometimes/Often/Socially/Regularly
Do you drink alcohol? (Please circle) Never/Seldom/Rarely/Sometimes/Often/Socially/Regularly
Do you use drugs? (Please circle) Never/Seldom/Rarely/Sometimes/Often/Socially/Regularly
Which drugs do/did you use?_____
Anything else you'd like to add:_____
Main concern you would like me to help you with: _____
Other relevant complaints: _____
When was the first time you were aware of the condition, when and how did it start? _____
_____
Have you been given a diagnosis for this condition? If so, what? _____
What kind of treatment(s) have you tried for this condition? _____
What makes it better?_____ What makes it worse?_____
Anything else you'd like to add:_____
What are any current emotional stressors in your life?_____
List dates and details of any major stress events:_____

### Pregnancies

Number of pregnancies: if more than one, how far apart?_____
Number of deliveries/C-Sections:_____
Have you had any miscarriages? When? Any complications?_____
What was your experience with pregnancy? Labor/Deliver? Any complications?_____
_____
Any serious accident? Trauma to tailbone? If so, when?_____
Any abdominal, pelvic, or back surgeries?_____
How long was your labor?_____

### Reproductive History

Do you experience pain with intercourse? Positional pain?_____
Do you experience orgasms?_____
Have you ever been sexually abused?_____
Libido? (Please circle) High/Medium/Low

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Do you have periods?_____ Are they regular/irregular?_____ How long do they normally last?_____
Are your periods: (Please circle) Heavy/Medium/Light **Date of last period?_____**
Do you experience: (Please circle) Cramps/Clots/Spotting
Do you experience any menopausal symptoms?_____
Assisted reproductive therapies:
IUIs?_____ How many?_____ Dates?_____
IVFs?_____ How many?_____ Dates?_____

**Please Circle Yes or No for the following:**

| | | | | | |
|---|---|---|---|---|---|
| Painful Periods | Yes/No | Bloating Before Period | Yes/No | Painful Ovulation | Yes/No |
| Late Periods | Yes/No | Breast Tenderness With Period | Yes/No | Poor Circulation in Feet | Yes/No |
| Early Periods | Yes/No | Frequent Urination | Yes/No | Swelling of Feet | Yes/No |
| Irregular Periods | Yes/No | Chronic Constipation | Yes/No | Cold Feet | Yes/No |
| Dizziness With Periods | Yes/No | Vaginal Dryness | Yes/No | UTI | Yes/No |
| Headaches With Periods | Yes/No | Vaginal Discharge | Yes/No | Bladder Infections | Yes/No |
| Varicose Veins | Yes/No | Menstrual Clots | Yes/No | Premature Deliveries | Yes/No |
| Tired/Weak/Numb Legs | Yes/No | Painful Intercourse | Yes/No | Difficult Menopause | Yes/No |
| Sore Heels | Yes/No | Infertility | Yes/No | Frequent Yeast Infections | Yes/No |
| Uterine Polyps | Yes/No | Pelvic Inflammation | Yes/No | Cystitis | Yes/No |
| Intense PMS | Yes/No | Dark Blood During Menses | Yes/No | Ovarian/Breast Cysts | Yes/No |
| Depression Before Period | Yes/No | Chronic Low Back Pain | Yes/No | Cancer | Yes/No |

If you answered yes to any of the above, please explain:_____
_____
_____

## Nutrition

| | | | | | |
|---|---|---|---|---|---|
| Do you smoke? | Yes/No | Do you exercise? | Yes/No | Do you eat lunch? | Yes/No |
| Do you drink alcohol? | Yes/No | Do you skip meals? | Yes/No | Do you eat dinner? | Yes/No |
| Do you drink water? | Yes/No | Do you eat meat? | Yes/No | Any food allergies? | Yes/No |
| Do you drink caffeine? | Yes/No | Do you buy organic? | Yes/No | | |
| | | Do you eat breakfast? | Yes/No | | |

If you have further information regarding any nutrition-related questions please comment (For instance, if you do any of the above moderately/excessively/seldom; list food allergies)_____
_____
_____

## Eating Disorder History

Have you ever had an eating disorder?_____
Do you have a history of binge eating?_____
Do you have a history of restricting your diet?_____
What foods, if common, would you binge on?_____
Do you suffer from constipation/bloating/gas/burning after eating?_____
How often do you have bowel movements?_____
Do you use laxatives/diuretics?_____How often?_____

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**Consent for Treatment**

I understand that services are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or techniques may be adjusted to my level of comfort. I further understand that services should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that the practitioner is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because treatment should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile during subsequent sessions and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the practitioner reserves the right to refuse to perform treatment on anyone whom he/she deems to have a condition for which treatment is contraindicated. I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent. I give my permission to share information regarding my treatment with my health care provider. I have been made aware of and agree to the terms of Element Natural Healing Arts' 24 hour cancellation policy and agree to be held responsible for any fees related to this policy.

HIPAA regulations require that all practitioners obtain a signed release form from their client *before* taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records. Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. Failure to comply with these confidentiality regulations could result in penalties.

I, (name) _____give my permission for _____, the Practitioner, to take notes about me, including health/medical history and/or personal information I choose to disclose to her/him. I understand this information may be used for the purpose of practitioner certification. All relevant identifying information will not be disclosed, such as name, address, SS number, or date of birth.

Client Signature_____ Date _____

Practitioner Signature_____Date_____