Integrative Pelvic-Abdominal Bodywork

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INTAKE FORM

Just fill out sections that may be relevant to the condition you're being seen for!

Name_____ _____ **Today's Date** _____

Birth Date_____**AGE**_____

Address_____

Phone_____ **Email** _____

Shall I add you to my email list for occasional massage discounts or announcements _____

Occupation_____

Emergency Contact Name, Relation & Phone_____

REFERRED BY_____

What major concern, symptom, problem brings you here?

_____

When and how did this begin? Was the first episode related to a specific incident? _____

_____

What tests/treatments have you received for this concern? (include other internal pelvic floor work, external abdominal bodywork, psychotherapy, or other treatments.)

_____

What relieves your symptoms? _____

About how many hours per day do you sit? ___Stand?___ Lift heavy things (kids)___

Frequency/type of Exercise/movement?_____

What is your goal for treatment? _____

Please list any other pertinent medical diagnosis/treatments:

_____

What feels supportive and joyful in your life?

_____

What is your most common Negative Self-Talk?

_____

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Womb/Moon/Fertility History: ___Not Applicable

Last Menstrual Period:_____ Length of Menses_____

___Heaviness in Pelvis prior to menses
___Dark Thick Blood at: Beginning//End__//Both__
___Excessive Bleeding : Pads/tampons per Hour___
___Episodes of Amenorrhea (cycles with no bleeding)
___Painful Periods
___Bloating
___Ovulation: __Painful ___Failure to Ovulate
___Uterine or Cervical Polyps/Fibroids
___Spotting
___Current yeast infection, herpes, STI
___History frequent yeast infections
___Headache/ Migraine/ Dizziness
___Sexually transmitted infection
___Water Retention / Bloating
___Endometriosis: Location (if known)
___Irregular cycles

Date of last PAP/Pelvic Exam_____Results_____ Past Abnormal Pap?_____

Birth control ___Not Applicable

Pills / *Patch* / *Diaphragm* / *Injection* / *Condoms* / *IUD* / *Abstinence* / *Rhythm method* / Other

Length of time used _____

___Currently Trying to Conceive
___ Fertility Concerns/Challenges. ___Assisted Reproductive Technology (IVF, IUI, 3rd party ART)

Sexual Energy/Libido: High_____Moderate_____ Low_____ None_____

Pregnancy history: ___Not Applicable

Pregnancies_____ #Births_____ # Miscarriages_____ #Terminations____

Twins or more_____ Last birth: Year/Type (vaginal or cesarean)_____

___ Currently Pregnant? _____ Due Date? _____

___History or current Preeclampsia
___Placenta Previa//Abruption
___Traumatic Birth experience
___Perineal Tearing during birth
___Episiotomy
___Forceps or vacuum at birth
___Vaginal Dryness
___Interventions in labor/birth/postpartum
___Other Childbirth complications_____
___Postpartum Hemorrhage
___Postpartum Depression/Anxiety
___ C-section_____

Pelvic-Abdominal

___Bladder infections
___Urinary Frequency
___Constipation /Diarrhea / Loose stools
___Irritable Bowel/Crohns/Celiac/SIBO
___Rectocele/ cystocele/ Fistula
___Urinary or Bowel incontinence/leaking
___Interstitial Cystitis
___Pelvic / abdominal pain or pressure
___Pelvic Organ Prolapse
___Pelvic Mesh
___Hemorrhoids
___Uterine Infection(s)
___Ovarian Cysts Location:_____
___Vaginal Dryness
___Pessary in place
___GERD
___Vaginal or Vulvar Pain
___Heartburn
___Painful vaginal penetration
___Herpes

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Surgeries: List any pelvic-abdominal surgeries_____Cervical: LEEP / Biopsy / Cerclage/ Other_____Tubal Ligation (tubes tied) ___D&C ___Myomectomy

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Menopause_____ ___Not applicable

___Hot flashes
___Insomnia / Disturbed Sleep
___Fatigue
___Memory Loss
___Mood Swings
___Vaginal Discharge/ Dryness
___Depression
___Anxiety
___Irritability
___Painful Intercourse

Age symptoms began:_____ Are they getting worse_____ better_____ same_____
Are you on/ or ever been on hormone replacement therapy?_____if so, how long_____
Name and dose_____
Reason for stopping_____

****

Musculo-skeletal

___History of Broken Bones_____
___Headaches /___Migraines
___Low back pain_____
___Leg pain/numbness/weakness
___Scoliosis
___Fibromyalgia
___Foot complaints
___Separated abdominal muscles (diastasis)
___Car or other major accident
___Spine/coccyx /sacrum injury or pain
___Bulging Disc/Disc issues
___Hip pain/ Sacro-iliac joint pain/
___Sciatica
___Back Surgery or injury
___Leg cramps
___Athletes foot/Skin disorders
___Hernia
____Rate current pain 0-10: (0-none/10-worst)

Psyche

___Birth Trauma from Your birth
___Depression
___Eating disorder_____
___Physical /Emotional abuse
___Sexual Abuse
___Drug/Tobacco/Alcohol use/abuse_____
___Persistent Negative Self-Talk
___Anxiety

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Medical

___Asthma
___Anemia
___Cancer_____
___High/ Low Blood Pressure
___Heart Conditions
___Kidney Infections/Stones
___Gall stones/Infections
___Appendicitis
___Thyroid Conditions
___Diabetes
___Seizures
___Autoimmune disorders
___Headaches
___Dizziness
___Medications that might affect your session:
___Varicose Veins, Blood clots
___Sensitivity to oils/lotions
___Other relevant info_____
___History Broken Bones
___**ALLERGY TO <u>VINYL</u> gloves**

I understand there is no implied or stated guarantee of success of effectiveness of individual techniques and acknowledge that massage is not a substitute for medical care/diagnosis. I have stated all conditions I am aware of and will inform my practitioner of any changes in my health status prior to sessions. I understand that a 24-hour notice is required to cancel a session with Leslie Stager and will pay for missed appointments without 24 hour notice. **SIGNATURE:** _____