WOMEN'S HEALTH

Date: **Client:**

Referred by:

GENERAL INFORMATION

Address:

Phone: Email:

Emergency contact (name/phone): Legal guardian if under 18:

DOB: Age:

Education/Occupation:

Living Situation (Marital status/pets/alone; home supportive/stressful; social/family/personal support):

Women's HEALTH INFORMATION

Do you experience any of the following, past or present? PLEASE CIRCLE

Breast pain, Irregular PAP, Difficulty getting pregnant, Endometriosis, STD's, HPV, Fibroids, Vaginal dryness, Ovarian cysts, Vaginal infection, Irregular menstrual cycles, Hot flashes, Difficult menopause, Pelvic pain, other _____

Currently pregnant?___ How many pregnancies? ___ Number of deliveries: ___ Vaginal ___ C-Section__ Last birth_____ Any complications? _____ Any problems like post-partum_____

Have you had any miscarriages? ___ If so, when? _____

Have you had any abortions? ___ If so, when? _____

Method of contraception: _____

Do you have an IUD? _____

Do you have any pain with intercourse? _____

Do you have difficulty achieving orgasm? _____

Do you have any problems with incontinence (difficulty holding your urine)? _____

Date of Last Menstrual Period? _____

MENSTRUAL PATTERN (check all that apply):

Symptom	*Yes*	*No*	*Explanation*
Painful Menstruation			
Clots			
Irregular Cycles			
Dark Blood at Onset			
Dark Blood at Conclusion			
Heaviness in Lower Pelvis			
Weak or Numb Legs			
Other:			

How many days do you bleed?_____ Light, medium, or heavy flow? _____

Date of last pelvic exam?

Have you ever been told you have a tipped or tilted uterus?

MENOPAUSE: Have you entered Menopause yet? _____ If so, at what age? _____

Please check below if you have experienced any of the following:

Hot Flashes ___ Memory Loss ___ Depression ___ Insomnia ___ Mood Swings ___ Fatigue ___

Do any of the women on your mother's side of the family suffer from any of the following:

Infertility ___ Menstrual Problems ___ Difficult Menopause ___

Are you now, or have you ever taken:

Birth Control Pills____ Hormone Replacement Therapy? ___

GENERAL: Do You Have or Have You Had Any of the Following?

High Blood Pressure ___ Acne ___ Anorexia/Bulimia ___ Diabetes ___ Headaches ___

Heart Problems ___ Hepatitis ___ Skin Rashes ___ Kidney Problems ___ Cancer ___ Skin Fungus ___

Fainting Spells ___ Frequent Cold or Flu ___ Sinus Problem ___ Emotional Problems ___

Digestive GI Health Conditions: (men & Women)

What is the reason for seeking an Abdominal Massage or Tallada Abdominal/Back Massage?

Have you been diagnosed with any digestive disorders? If yes, please specify the condition(s).

Are you currently experiencing any symptoms related to your digestive system?

Have you had any recent changes in your bowel movements?

How often do you have bowel movements?
Are you constipated?
Do you have diarrhea?

Have you undergone any surgeries related to the digestive system? If yes, please specify the type of surgery and date.

Are there any areas of your abdomen that are sensitive to touch or pressure? If yes please specify the areas.

Do you have any allergies or sensitivities to massage oils?

Is there anything else you would like to share about your digestive health?

Health Conditions: (men & women fill this out)

Current overall health condition: ___Excellent ___Very Good ___Good ___Fair ___Poor

Health concerns:

Current nutritional status: ___Excellent ___Very Good ___Good ___Fair ___Poor

Current active healthcare professionals (physicians/D.O./chiropractor/nutritionist/bodyworkers/etc.)

Medical conditions with diagnoses dates/years:

Hospitalizations/surgeries (date/year/complications):

Accidents/physical injuries HIP OR BACK injuries (date/year/complications):

Mental health conditions/disorders with diagnoses dates/years:

Sleep quality/sleep aid usage/average hours of sleep per night:

Current prescription/over-the-counter medications:

Supplements Used: __Vitamins ___Minerals __Herbs __Homeopathic __Flower Essences __Other

Current **Self-Care** practices (exercise, meditation, relaxation, body care, journaling, hobbies, interests):

Spiritual beliefs/practices/affiliations:

Is your belief a source of support to you? Word/Name(s) you use for Higher Power?

AREAS OF CONCERN

Signature:_____ Date: _____