

## FERTILITY MASSAGE INTAKE FORM

Name: \_\_\_\_\_ Date of Initial Visit: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Have you had a massage or bodywork before? \_\_\_\_\_ If so, what type(s)? \_\_\_\_\_

What is your primary concern?

Secondary concerns?

What makes it better?

Worse?

Describe the exact location of your pain:

Does this condition interfere with work, sleep or recreation? If so, please describe.

Describe your exercise routine:

Describe your stress level on a scale of 1-10, and in detail if you wish?

Are you currently under the care of another healthcare practitioner(s)? If so, please describe why.

Current Medications (list all):

Allergies:

Do you use Tobacco?                      Quantity (ppd)?

Alcohol?                                      Quantity (ounces/day)?

Have you ever been treated for substance abuse? If so, please describe.

Have you ever had surgery or any procedure preformed? If so, please describe.

Have you ever been hospitalized? If so, please describe.

Please check any of the following conditions you currently have or have had in the past:

- |   |   |
|---|---|
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> ringing ears           |
| <input type="checkbox"/> Tingling sensations        | <input type="checkbox"/> cold hands and or feet |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> swollen ankles         |
| <input type="checkbox"/> Sinus conditions           | <input type="checkbox"/> swollen joints         |
| <input type="checkbox"/> Painful joints             | <input type="checkbox"/> skin disorders         |
| <input type="checkbox"/> Sciatica                   | <input type="checkbox"/> anxiety                |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> fatigue                |
| <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> trouble sleeping       |
| <input type="checkbox"/> Varicose veins             | <input type="checkbox"/> herniated discs        |
| <input type="checkbox"/> High or low blood pressure |   |
| <input type="checkbox"/> Respiratory conditions     |   |

## FEMALE HEALTH HISTORY

Age when you got your period:

Have you ever been pregnant?

Deliveries:

Terminations:

Miscarriages:

Please check if you are experiencing or have experienced any of the following.

- |  |  |
|--|--|
| <input type="checkbox"/> Amenorrhea        | <input type="checkbox"/> endometriosis           |
| <input type="checkbox"/> Painful periods   | <input type="checkbox"/> irregular periods       |
| <input type="checkbox"/> Painful ovulation | <input type="checkbox"/> severe cramping         |
| <input type="checkbox"/> Tired limbs       | <input type="checkbox"/> numbness                |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> pain during intercourse |
| <input type="checkbox"/> Constipation      | <input type="checkbox"/> loose stools            |
| <input type="checkbox"/> Polyps            | <input type="checkbox"/> fibroids                |
| <input type="checkbox"/> UTI               | <input type="checkbox"/> Yeast infection         |
| <input type="checkbox"/> Vaginal dryness   | <input type="checkbox"/> cysts                   |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> anxiety                 |

Have you ever had a sexually transmitted disease? If so, please describe.

Do you have a history of sexual trauma?

Are you being treated for infertility? Please give a brief description of past and current treatments.

Any other Gynecological issues I should be aware of?

## PAYMENT POLICY

I understand that a payment of \$120 is due at the time of treatment paid by cash or check.

## CANCELLATION POLICY

Appointments that are not cancelled or rescheduled within 24 hours of your scheduled appointment time will be billed the full treatment amount to you.

## MEDICAL CONSENT

I understand that Fertility Massage Therapy does not replace medical care. I understand that the massage therapist does not diagnose any medical conditions or illnesses, prescribe medications or perform any spinal manipulations. Because massage therapy is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly to the best of my knowledge. I agree to keep the practitioner updated as to any changes in my medical profile, and I understand that there shall be no liability on the practitioner's part should I forget to do so.

I have read and under fully understand the above statements.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date