zoe lotus healing arts
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Maya Abdominal Massage Health History

Name: _____ Date of Initial Visit _____

Address _____State _____Zip_____ Home Phone _____

Work Phone _____ Cell _____email_____

Date of Birth _____ Age_____Occupation _____

Marital/Relationship status _____ Referred by _____

Client Confidentiality Release Form

I understand that payment is due at the time of treatment unless arrangements have been made other wise.

I agree to give at least 24hourse notice of cancellation of appointment.

Cases of extreme emergency are considered exceptions to this cancellation policy.

I understand the treatment here is not a replacement for medical care.

I understand the therapist/practitioner does not diagnose medical illness, disease or any other physical or mental conditions (unless specified under his/her professional scope of practice)

As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice)

I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.

I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Client signature _____Date_____

Therapist/Practitioner signature: _____ Date_____

HIPAA regulations require all practitioners should have a signed release form from their client before taking any notes about them. Clients may 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) _____address _____
give my permission, for my therapist/practitioner, _____ to take notes about me, including health history/ medical and /or personal information I choose to disclose to him/her.

Signature:_____ Date: _____

Revised on 04/22/08

REASON FOR VISIT

Primary reason for visit: _____

When did your first notice it? _____What brought it on? _____

Describe any stressors occurring at the time_____

What activities provide relief? _____ what makes it worse? _____

Is this condition getting worse?_____ interfere with work_____sleep_____ recreation _____

Have you had massage/bodywork before?_____What type? _____

MEDICAL HISTORY

Are you currently under the care of another health care provider(s)?_____ Reason (s)_____

_____

_____

Name(s) of Practitioner_____ Address: _____

Phone_____email _____

Current Medications and /orSupplements/Remedies: _____

_____

_____

Allergies: specify allergen and reaction: _____

_____

_____

Surgical History (year and type) and/or Recent Procedures:_____

_____

_____

Hospitalizations_____

_____

_____

Accidents or Traumas _____

_____

_____

Falls/Injuries to Sacrum/head/tailbone (describe) _____

_____

_____

Other: _____

_____

_____

_____

_____

Please review and check the following:

Headaches Type:	Past Present	Pins and Needles in arms legs, Hands or feet	Past Present
Asthma		Spinal Problems	
Cold Hands or feet		Anxiety	
Swollen ankles		Depression	
Sinus Conditions Frequent Colds		Sleep Disturbance	
Seizures		Fainting Spells	
Loss of smell or Taste		Loss of Memory	
Skin Disorders: Type		Varicose Veins Hemorrhoids Location	
Sciatica		Muscular Tension: Location:	
Painful/Swollen Joints		Herniated/Bulging Discs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Artifical/Missing limbs	

Other (not mentioned above)

Do you use Tobacco?_____ Quantity_____/ppd Alcohol?_____Quantitiy_____ounces/ day
Marijuana?_____Quantity_____Other:_____Have you been under treatment for substance use?

FAMILY HISTORY			
	Still Living?	Cause of Death/age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			

Other:

DIGESTION AND ELIMINATION

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____ Water Intake(glasses/day)_____ Caffeine_____

What is the worst item in your diet _____ What foods are your weakness _____

Are you subject to binge eating? _____ What foods _____

Do you experience bloating/gas/burps after eating? _____ What foods trigger this?_____

How often are your bowel movements? _____ Do your stools: sink_____float_____

Constipation? _____ Blood in stool ? _____Mucus in stool? _____Pain when stooling? _____

Other concerns _____

EMOTIONAL & SPIRITUAL

What is your opinion of yourself?_____

If possible, please describe the most negative emotion you experience_____

When do you most often feel this emotion:_____Where are you? _____

Do you pray to or have a spiritual practice _____

On a scale of 1 – 10 (1 being the lesser, 10 the greater) Please rate yourself:

Faith _____ Hope_____Charity _____Generosity _____ Sense of Humor _____

Sense of Fun _____ Fear _____Grief _____Other (describe briefly)_____

What are hobbies/ activities that provide you with a sense of pleasure and accomplishment _____

_____

Describe your exercise routine (type, frequency) _____

_____

What changes would you like to achieve in 6 months_____

One Year _____

FEMALE REPRODUCTIVE HEALTH HISTORY

When did you begin your menses _____ What was this like for you _____

How many Pregnancie(s) have you had?_____Number of Deliverie(s)_____Dates _____

Termination(s)_____When _____

Miscarriage(s)?_____When _____

Complications _____

What was your experience of: Pregnancy _____

Labor _____

Delivery _____

Post Partum _____

Medications your mother took when she was pregnant with you (if any) _____

Birth Trauma if known _____

Maternal Family History of (please circle) Infertility Fibroids Endometriosis------PMS Menopause

Cancer(type)_____Menstrual Problems Other_____

Method of Contraception (circle) pills patch diaphram injection condoms IUD abstinence rhythm method

Fertility Awareness Other:_____ Length of time using method _____

Last Pap smear _____ Results (if known)_____

Date of Last Menstrual period_____ Length of Menses_____ Are you Pregnant/Trying to Conceive _____

Episodes of Amenorrhea_____When_____For how long _____

Please check as appropriate:

- ☐ Painful Periods
- ☐ Dark thick blood at the end of cycle
- ☐ Bloating/Water Retention with period
- ☐ Excessive Bleeding (→ one pad/hour)
- ☐ Varicose Veins
- ☐ Sore heels when walking
- ☐ Constipation
- ☐ Uterine Polyps
- ☐ Bladder Infections/Incontinence
- ☐ Premature deliveries
- ☐ Pelvic Inflammation
- ☐ Difficult menopause
- ☐ Irregular Cycles (early or late)
- ☐ Headache or Migraine with period
- ☐ Heaviness in pelvis with period
- ☐ Failure to Ovulate
- ☐ Tired weak legs
- ☐ Low back ache
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Chronic Miscarriage
- ☐ Incompetent cervix
- ☐ Sexually Transmitted disease
- ☐ Cancer esp of reproductive area
- ☐ Dark, thick blood at beginning of cycle
- ☐ Dizziness with period
- ☐ PMS/Depression with or before period
- ☐ Painful Ovulation
- ☐ Numb legs and feet when standing
- ☐ Painful intercourse
- ☐ Endometritis/Uterine Infections
- ☐ Vaginal Discharge/Vaginitis/
- ☐ Weak newborn infants
- ☐ Spotting with pregnancy
- ☐ Dry Vagina
- ☐ Cysts esp breast/ovarian

Other: _____

_____

Are you under the treatment for Infertility_____Describe current treatment to date : _____

(IUI, IVF,etc)_____

Gynecological Provider: _____ Address_____Phone_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms _____

Have you experienced a history of rape_____trauma_____incest_____If so,-when _____

Did you undergo counseling for this _____

What was this like for you_____

_____

MENOPAUSE *(Check the symptoms that apply to you)*

☐ Hot flashes	☐ Insomnia	☐ Fatigue	☐ Memory Loss	Mood Swings
☐ Vaginal Discharge	☐ Dry Vagina	☐ Depression	☐ Anxiety	Irritability
☐ Spotting	☐ Flooding	☐ Irregular Menses	☐ Painful Intercourse	Increased Libido
☐ Decreased Libido	☐ Disturbed Sleep Pattern			

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 _____

Age of Mother at menopause: _____ Concerns/Experience _____

Additional Comments: _____

_____

_____

_____

_____

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