FOR OFFICE USE:
CC ENTRY_____

CONFIDENTIAL FERTILITY CLIENT INFORMATION

TODAY'S DATE: _____

Name:_____ _____ _____

Address: _____ City:_____ State: _____ Zip: _____

Phone (h): _____ (w) _____ (cell) _____

Date of Birth: _____

Employer: _____ Occupation: _____

Referred by:_____ Your e-mail:_____

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

What is your primary concern?_____

Secondary concerns?_____

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:

□ Headaches
□ ringing ears
□ Tingling sensations
□ Cold hands and or feet
□ Asthma
□ Swollen ankles
□ Sinus conditions
□ Swollen joints
□ Painful joints
□ Skin disorders
□ Sciatica
□ Anxiety
□ Depression
□ Fatigue
□ Dizziness
□ Trouble sleeping
□ Varicose veins
□Herniated discs
□ High or low blood pressure
□ Respiratory conditions

FEMALE HEALTH HISTORY

Age when you got your period: _____

Have you ever been pregnant?_____

Deliveries: Vaginal_____ C-section _____Terminations:_____ Miscarriages: _____

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

□ Amenorrhea
□ Endometriosis
□ Painful periods
□ Irregular periods
□ Painful ovulation
□ Severe cramping
□ Tired limbs
□ Numbness
□ Back pain
□ Pain during intercourse
□ Constipation
□ Loose stools
□ Polyps
□ Fibroids
□ UTI
□ Yeast infection
□ Vaginal dryness
□ Cysts
□ Depression
□ 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?_____

_____

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.

_____ _____

Signature Date