

# Gen-Touch Massage & Holistic Therapy



Locations: San Diego & Solana Beach  
619.865.6619

## CONFIDENTIAL FEMALE - FERTILITY CLIENT HOLISTIC HEALTH INTAKE FORM

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Marital Status:  Single  Married  Divorced. If married, how long? \_\_\_\_\_

Have you ever had massage/bodywork before?  Yes  No If yes, what type: \_\_\_\_\_

Referred by: \_\_\_\_\_

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### REASON FOR VISIT

What is your primary concern? \_\_\_\_\_

What are other areas of concern? \_\_\_\_\_

When did you 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? \_\_\_\_\_

Describe your exercise routine (type, frequency): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### FAMILY HEALTH HISTORY

	Still Living? Y or N	Age	If Deceased, Cause and Age of Death	Major Health Issues
Mother				
Father				
Siblings				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				
Paternal Grandmother				

### FAMILY HISTORY

Family History of Abuse or Extreme Conditioning? Check if applicable:  physical  emotional  
 sexual  spiritual. If any check, please briefly describe: \_\_\_\_\_

Family History of Substance Abuse \_\_\_\_\_ Suicide \_\_\_\_\_  
 Other Trauma \_\_\_\_\_

### MATERNAL HISTORY

Medications your mother took when she was pregnant with you (if any)? \_\_\_\_\_

Maternal Family History of (check if appropriate)  Infertility  Fibroids  Endometriosis  PMS  
 Cancer (type): \_\_\_\_\_  Other Menstrual Problems (type): \_\_\_\_\_  
 Menopausal Symptoms (type): \_\_\_\_\_  
 Age of Mother at menopause: \_\_\_\_\_ Concerns/Experience: \_\_\_\_\_

### 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 emotionally? \_\_\_\_\_  
 Do you pray 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 \_\_\_\_\_ Sense of Joy \_\_\_\_\_ Fear/Anxiety \_\_\_\_\_ Grief \_\_\_\_\_  
 Anger: \_\_\_\_\_ Guilt: \_\_\_\_\_ Worry: \_\_\_\_\_ Other (describe briefly): \_\_\_\_\_  
 What are your hobbies/activities that provide you with a sense of pleasure and accomplishment?  
 \_\_\_\_\_

What changes would you like to achieve in 6 months? \_\_\_\_\_  
 Changes in one year? \_\_\_\_\_

DIGESTION & ELIMINATION

Typical Breakfast: \_\_\_\_\_

Typical Lunch: \_\_\_\_\_

Typical Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_ Water Intake: \_\_\_\_\_ (glasses/day) Caffeine: \_\_\_\_\_

Do you eat organic foods?  Yes  No. If yes, which foods? \_\_\_\_\_

What is the worst thing on your diet? \_\_\_\_\_

What foods are your weakness? \_\_\_\_\_

Are you subject to binge eating?  Yes  No. If yes, what foods? \_\_\_\_\_

Do you experience bloating/gas/burps after eating?  Yes  No. If yes, what foods trigger this? \_\_\_\_\_

How often are your bowel movements? \_\_\_\_\_ Do your stools:  sink  float

Constipation?  Yes  No. If yes, how often? \_\_\_\_\_ Blood in stool?  Yes  No. If yes, how

often? \_\_\_\_\_ Mucus in stool?  Yes  No. If yes, how often? \_\_\_\_\_ Pain when stooling?

Yes  No. If yes, how often? \_\_\_\_\_ Do you have any of the following digestive or elimination

issues? (please circle all that apply):

IBS (Irritable Bowel Syndrome)

Acid Reflux

Diverticulitis

Small amounts of food = feel full

Gastritis

Diarrhea

Chronic Indigestion or Heartburn

Crohn's Disease

Vomit after meals

Multiple Food Allergies

Celiac Disease

Ulcerative Colitis

Other concerns with digestion or elimination: \_\_\_\_\_

MEDICAL HISTORY

Are you currently under care of another health care provider(s)?  Yes  No.

Reason(s): \_\_\_\_\_

Name(s) of Practitioner: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies (specify allergen and reaction): \_\_\_\_\_

Supplements/Remedies: \_\_\_\_\_

Do you use Tobacco?  Yes  No. If yes, quantity: \_\_\_\_\_ pack/day. Alcohol?  Yes  No.

If yes, quantity: \_\_\_\_\_ ounces/bottles/glasses/day. Marijuana?  Yes  No. If yes,

quantity \_\_\_\_\_ Other Substances:  Yes  No. If yes,  Currently?  Past? What kind?

\_\_\_\_\_ Quantity \_\_\_\_\_ Frequency (circle) per day/week/month.

Have you been under treatment for substance abuse?  Yes  No. If yes, describe: \_\_\_\_\_

Surgical History (year and type): \_\_\_\_\_

Recent Procedures: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Accidents or Traumas: \_\_\_\_\_

Falls/Injuries to sacrum/head/tailbone (describe) \_\_\_\_\_

Birth Trauma, if known: \_\_\_\_\_

MEDICAL HISTORY (Continued)

CIRCLE any of the following you are CURRENTLY experiencing UNDERLINE any of the following you have experienced in the PAST

Headaches (migraine, tension, cluster) Ring in the Ears  
 Pins and Needles in arms, hands and/or feet Asthma Cold Hands or Feet  
 Swollen ankles Sinus Conditions Seizures Loss of Smell or Taste  
 Skin Disorders: Acne, Fungus, Psoriasis, Other: \_\_\_\_\_ Sciatica  
 Painful Joints Swollen Joints Spinal Problems Anxiety Depression Fatigue  
 Trouble Sleeping Fainting Spells Loss of Memory High or Low Blood Pressure  
 Muscular Tightness (location): \_\_\_\_\_ Varicose Veins (location): \_\_\_\_\_  
 Herniated or Bulging disc (location): \_\_\_\_\_ Contact Lenses Dentures  
 Artificial/Missing Limbs Frequent Colds/Upper Respiratory conditions

Describe any other current persistent pain or tension or any other conditions you may have below:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

FEMALE – REPRODUCTIVE HEALTH HISTORY

Age of Menarche: \_\_\_\_\_ What was this like for you? \_\_\_\_\_  
 Date of your last Menstrual period: \_\_\_\_\_ Length of Menses: \_\_\_\_\_  
 What is a typical menses for you?

	Flow: Heavy=H Medium=M Light=L	Color: Brown=B Dark Red=DR Bright Red=BR	Clots or Tissue? Clots = C Tissue = T What size?	Pain or Discomfort? Level of Pain or Discomfort 1 = Very Mild to 10 = Intense Location of the Discomfort?
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
Day 7				

Do you take pain medication during your menses?  Yes  No. If Yes, what type and how much do you take? \_\_\_\_\_ How long is your complete cycle: \_\_\_\_\_  
 Episodes of Amenorrhea  Yes  No. If yes, when? \_\_\_\_\_ For how long? \_\_\_\_\_  
 Date of Last Pap Smear: \_\_\_\_\_ Results (if known): \_\_\_\_\_

FEMALE – REPRODUCTIVE HEALTH HISTORY (Continued)

How many Pregnancies have you had? \_\_\_\_\_ Number of Deliveries? \_\_\_\_\_

Dates of Deliveries: \_\_\_\_\_

Terminations:  Yes  No. If yes, when? \_\_\_\_\_

Miscarriage(s)  Yes  No. If yes, when? \_\_\_\_\_

Complications? \_\_\_\_\_

What was your experience of Pregnancy? \_\_\_\_\_

Labor? \_\_\_\_\_

Delivery? \_\_\_\_\_

Post Partum? \_\_\_\_\_

Method of Contraception (check current method(s) and underline past)  pills  patch

diaphragm  injection  condoms  IUD  abstinence  rhythm method

Other \_\_\_\_\_

Length of synthetic contraception (pill, patch, injection): \_\_\_\_\_

Please circle as appropriate:

Painful periods

Dark thick blood at beginning or end of cycle

Headache or migraine with period

PMS/Depression with or before period

Painful ovulation

Heaviness or pressure in lower pelvis with period

Irregular (late or early)

Dizziness with period

Excessive bleeding (> one pad/hour)

Failure to ovulate

Bloating/water retention with period

Other symptoms (Circle and describe as indicated):

Varicose Veins of leg

Numb legs and feet when standing still

Low back aches

Constipation

Endometritis

Polycystic Ovarian Syndrome (PCOS)

Uterine Infections

Bladder Infections

Vaginal Yeast Infections

Premature Deliveries

Difficult pregnancy

Spotting with pregnancy

Dry vagina (without menopause)

Other reproductive issues (please specify): \_\_\_\_\_

Sexually Transmitted Disease (date and type): \_\_\_\_\_

Cysts (describe): \_\_\_\_\_

Fibroids (Size and location, if known): \_\_\_\_\_

Vaginal Discharge (describe): \_\_\_\_\_

Rate your interest in Sex:  High  Moderate  Low  None

Do you have or ever had difficulty experiencing orgasms?  Yes  No  Sometimes

FEMALE – REPRODUCTIVE HEALTH HISTORY (continued)

Have you experienced a history of rape? \_\_\_\_\_ trauma \_\_\_\_\_ incest \_\_\_\_\_  
molestation \_\_\_\_\_ If so, at what age and do you remember by whom?: \_\_\_\_\_

Have you shared this experience with your parents, a friend or anyone? \_\_\_\_\_

Did you undergo counseling for this?  Yes  No If yes, at what age and for how long? \_\_\_\_\_

What was counseling like for you and did you feel it helped? \_\_\_\_\_

FERTILITY

How long have you been trying to get pregnant? \_\_\_\_\_

Are you tracking your Basal Body Temperature (BBT)?  Yes  No. If yes, please provide copies of charts for the 3 most current months.

Do you track your ovulation?  Yes  No. If yes, how do you track (OV kit or cervical mucus, etc.)? \_\_\_\_\_ If yes, what day of your cycle do you ovulate? \_\_\_\_\_

Have you had any fertility issue or reproductive organ tests (dates & results)? HSG? \_\_\_\_\_

Transvaginal Ultrasound? \_\_\_\_\_ Hysteroscopy?: \_\_\_\_\_

Laparoscopy: \_\_\_\_\_

Have you had your hormones tested (dates & results)? FSH? \_\_\_\_\_ Other? \_\_\_\_\_

Are you, currently under any Western Medicine treatments for Fertility?  Yes  No. If yes, describe current treatment(s) to date:

Medications (alone, such as Clomid, etc): \_\_\_\_\_

IUI's (medications and dates): \_\_\_\_\_

IVF's (medications and dates): \_\_\_\_\_

If not currently under the treatment for Fertility, do you have any future plans to do Fertility treatments? \_\_\_\_\_

Has your husband's sperm been tested?  Yes  No. If yes, please provide date and results: Count? \_\_\_\_\_ Motility? \_\_\_\_\_ Morphology? \_\_\_\_\_

If there is Male Factor involved, is your husband getting any type of medical or alternative (ie. Acupuncture or herbs) treatment? If yes, what kind? \_\_\_\_\_

Gynecological Provider or Reproductive Endocrinologist: \_\_\_\_\_

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

Are you, currently under any Alternative treatments for Fertility?  Yes  No. If yes, describe current treatment(s) to date:

Fertility Acupuncture? If so, Acupuncturist: \_\_\_\_\_

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

Hypnosis/Hypno-fertility? If so, Hypno-Therapist: \_\_\_\_\_

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

Nutrition Fertility Specialist? If so, Nutritionist: \_\_\_\_\_

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

Where are you emotionally in your fertility journey and have you shared your concerns and challenges with anyone? \_\_\_\_\_

How committed are you to your holistic fertility journey (1=slightly committed to 10=incredibly committed)? \_\_\_\_\_



**Please read and sign:**

- 1) I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
- 2) I agree to give at least 24 hours notice of cancellation of appointment or I may be charged a cancellation fee. Cases of extreme emergency are considered exceptions to this cancellation policy.
- 3) I understand the treatment is not a replacement for medical care.
- 4) I understand the 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 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).
- 5) I understand that the treatment is not a substitute of medical treatment and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.
- 6) I have stated all my known conditions and take it upon myself to keep the practitioner updated on my health.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Practitioner signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Client Confidentiality Release Form**

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. The practitioner does not sell or release your personal information for use outside our clinic. Your e-mail will be used solely to communicate clinic-related information to you. You may request to be removed from our e-mail list at any time.

I, (name) \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ E-mail \_\_\_\_\_

give my permission, for my practitioner, Genevieve Siegel, to take notes about me, including health history/medical and/or personal information I choose to disclose to her.

I also understand that this information may anonymously be used for the Arvigo Institute, LLC for statistical purposes, and that my practitioner may use this information to provide me with a summary for my own personal use.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_