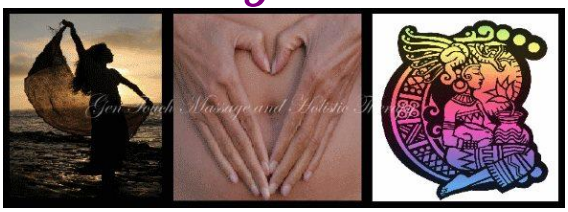
Gen-Touch Massage & Holistic Therapy



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: _____

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 positive emotion you experience: _____
When do you most often feel this emotion? _____
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	Irregular (late or early)
Dark thick blood at beginning or end of cycle	Dizziness with period
Headache or migraine with period	Excessive bleeding (> one pad/hour)
PMS/Depression with or before period	Failure to ovulate
Painful ovulation	Bloating/water retention with period

Heaviness or pressure in lower pelvis with period

Other symptoms (Circle and describe as indicated):

Varicose Veins of leg	Tired weak legs
Numb legs and feet when standing still	Sore heels when walking
Low back aches	Painful intercourse
Constipation	Endometriosis
Endometritis	Uterine Polyps
Polycystic Ovarian Syndrome (PCOS)	Adenomyosis
Uterine Infections	Frequent urination
Bladder Infections	Vaginitis
Vaginal Yeast Infections	Chronic miscarriages
Premature Deliveries	Weak newborn infants
Difficult pregnancy	Incompetent cervix
Spotting with pregnancy	Pelvic Inflammation
Dry vagina (without menopause)	Difficult 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 Basil 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. Acunpuncture 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)?_____

PERI-MENOPAUSE (Circle the symptoms that apply to you)

Hot flashes	Insomnia	Fatigue	Memory Loss
Mood Swings	Irritability	Vaginal discharge (describe): _____	
Dry Vagina	Fatigue	Depression	Spotting (menses)
Flooding	Clotting	Irregular menses	Increased/Decreased Libido

Other symptoms not listed above: _____
When did these symptoms begin? _____
Are they getting worse? □ Yes □ No. Better? □ Yes □ No. Same □ Yes □ No.
Other medications/herbal remedies: _____
Additional comments about peri-menopausal symptoms: _____
_____
_____
_____
_____

ADDITIONAL COMMENTS

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:_____