MAYA ABDOMINAL HEALTH INTAKE FORM

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All answers are confidential.

Date: _____

Name: _____ Date of Birth: _____

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

Is it ok to contact you via email? Yes: _____ No:_____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

Gender: _____ Marital Status: _____ Occupation: _____

Referred By: _____ Emergency contact & phone#_____

Primary Care Physician: _____ Phone #: _____

Are you currently/within the last year been under the care of your Primary Care Dr.?_____

What conditions? _____

Describe your main concerns (Symptoms, onset, diagnoses, duration, etc.)

_____
_____
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_____

What makes your condition better? (rest, movement, heat, cold, fresh air, eating, crying, etc.)_____

_____

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.) _____

_____

Any other related symptoms or other areas of tension? (Headache, Insomnia, Nausea, etc.) _____

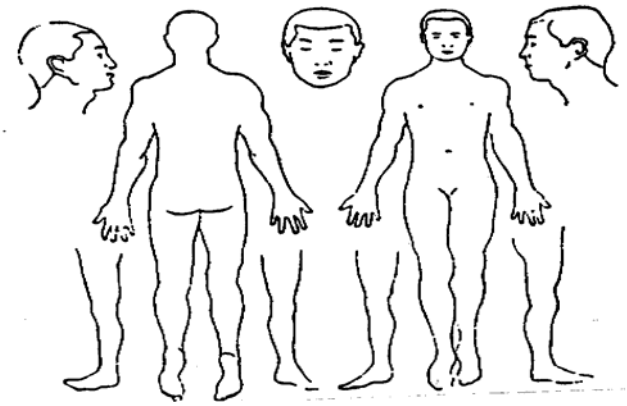
_____

Trauma (emotional, physical), Surgeries, accidents, injuries, chronic illness: (please include date).

_____

Union Center For Healing Integral PLLC Confidential

Please indicate where your symptoms are occurring & indicate any pain, tenderness, burning, numbness, tingling, stiffness, swelling, bruising, open wounds, scars, etc.



Allergies/Intolerances: (Nuts, oils, food, chemical, environmental, drugs, etc.)_____

_____

Medications: (names & dosages) Please attach an additional page if necessary._____

_____

Vitamins/Supplements/Herbs: _____

_____

Exercise

Days per week Length of workout Type of Activity

Personal History- Some conditions require extra care when receiving Maya Abdominal Massage.

Please check any conditions you have now or have had in the past.

Condition	Present	Past	Condition	Present	Past
Headache Type:			Cancer Type:		
ALLERGY TO NUT OILS			Blood Clots		
Asthma			**Pregnancy**		
Cold Hands/Feet			Dental gum problems		
Swollen Ankles			Alcoholism		
Sinus Congestions			Allergies: List		
Frequent Colds			Liver/Gallbladder Disease		
Seizures			Hyper/hypoglycemia		
Skin Disorder Type:			Diabetes		
High/Low blood pressure			Hepatitis		

Condition	Present	Past	Condition	Present	Past
Anxiety			Bruises easily		
Depression			Bleeding disorder		
Sleep disturbances			Muscle Weakness/Fatigue		
Fainting			Kidney Disease		
Artificial limbs			Stroke		
Fever			Sweats Easily		
Tremors			Changes in Appetite		
Chills			Poor Balance		
Localized Weakness			Weight Loss/Gain		
Night Sweats			Immune Compromised		

Condition	Present	Past	Condition	Present	Past
Low Back Pain			Numbness Feet when standing		
Sciatica			Heel Pain when walking		
Painful/Swollen Joints-Location:			Muscular Tension-Location:		
Herniated Disc/Bulging-Location:			VaricoseVeins/ Hemorrhoid - Location:		

Family Medical History

F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather)

☐**Diabetes** ___ ☐**Seizures** ___ ☐**Heart Disease** ___ ☐**Stroke** ___
☐**High Blood Pressure** __ ☐**Allergies** ___ ☐**Cancer** ___ ☐**Asthma** ___

Digestion and Elimination

Typical Breakfast: _____
Typical Lunch: _____
Typical Dinner: _____
Snacks _____ Water _____ Caffeine drinks _____ Cigarettes _____
Worst items in your diet: _____ Do you binge eat? _____
What foods are your weakness: _____
Do you experience gas/bloating/burping? _____
Foods you have sensitivities/allergies to:
_____
Bowel movements per day _____ Wellformed _____ Loose _____ Constipatio: _____
Pain with BM _____ Mucus _____ Blood _____ Sink _____ Float _____ Other? _____
Other: _____

Female Reproductive History

Are you pregnant or possibly pregnant? _____ Date of last menses _____
Method of contraception: Present _____ Past _____
Last OB/Gyn check up _____
Are you trying to conceive? _____ If so, how long_____
Are you working with any fertility specialists? If so, who/clinic? _____
Current fertility treatment _____
Previous treatments: IVF/IUI, medicated or non medicated, etc.:
Date: Treatment:
Date: Treatment:
Date: Treatment:

Other health care providers you work with: _____

Age of menstruation _____ Cycle of menses per month _____ Length _____

Check if you have this condition/symptom now or in the past.

Condition	Present	Past	Condition	Present	Past
Painful Periods			Irregular cycles Early		
Heaviness in Pelvis prior to menses			Dark Thick Blood at: Beginning/ End		
Excessive Bleeding Pads per Hour			Headache or Migraine with menses		
Dizziness			Bloating		
Water Retention			Ovulation: Painful or Anovulation		
Endometriosis Location (if known)			Fibroids Location (if known)		
Uterine or Cervical Polyps			Uterine Infection(s)		
Vaginal Infection(s)			Cysts Location:		
Bladder Infection(s)			Urinary Incontinence		
Painful Intercourse			Vaginal Dryness		
Episodes of Amenorrhea How long?					

Maternal Family History of:
Infertility_____ Fibroids _____ Endometriosis _____ Early onset menopause _____
PMS/Menstrual issues _____ Other _____

Medications your Mother took while pregnant _____
Your birth trauma if known _____

Pregnancy History

Number of pregnancies _____ Miscarriages _____ Terminations _____
Dates of live births _____
Complications _____
Premature Births _____
Spotting during pregnancy? _____ Incompetent Cervix? _____
Other _____

Briefly describe your experience with:
Pregnancy:

Labor:

Birthing:

Post partum:

Menopause

Age symptoms began _____ Getting worse/better/same? _____

Circle 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	Other:	Other:	Other:

Are you on any supplemental hormones?_____

Male Reproductive History

Are you currently trying to conceive?_____ How long? _____ Contraception? _____

Results of Sperm Analysis if known _____

_____

Are you working with a fertility clinic? _____ Treatments? _____

_____

Please check the symptoms that apply to you:

Painful Urination	Past Present	Urinary Retention	Past Present
Urinary Incontinence or Dribbling		Difficult starting or holding urine stream	
Weak or Interrupted Urine flow		Blood or pus in urine	
Pain or Burning with Urination		Pelvic pressure	
Nocturnal Urination How many times?		Insatiable sex drive	
Pain in lower back, esp After intercourse		Pain or Discomfort Between scrotum and Testicles	
Pain or Discomfort in: Penis Testicles Rectum		Pain or Discomfort in Inner thighs: Left Right Both	
Frequent Bladder or Kidney Infections When?		Erection: Difficulty in Obtaining Maintaining	

List any current or previous conditions/concerns: _____

_____

_____

Other Test Results: _____

Family history of prostate disease? _____

Treatment Consent Form

I understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation and energy flow. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to hold harmless and release from any liability employees of Union Center For Healing Integral PLLC for any condition or result, known or unknown that may arise as a consequence of any treatment that I receive.

I also understand and agree that if I make any illicit or sexually suggestive remarks or if I exhibit any sexual misconduct, I will be liable for payment for the "full" scheduled session, the appointment will end immediately, and I will not be allowed to receive massage at this establishment in the future.

The following are contraindications for massage (or should be consulted by your physician first):
Acute infectious diseases, Skin rashes, Atherosclerosis, Embolism or thrombus (blood clotting), Some cancers, Fever, Heart attack (OK after complete recovery), Herpes, Massage is ok when there are no visible lesions, High risk pregnancy, Skin infections, Skin lesions/open wounds/sores, Thrombophlebitis (blood clot), Diabetes with vascular dysfunction, Bursitis, Burns, Artificial blood vessels, Tendon & Muscle Ruptures. If you have been diagnosed or are experiencing any of the above**, please indicate on the Intake Form and inform the practitioner.**

I will notify the therapist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points could induce miscarriage.

Printed Name_____Signature _____ Date_____

(Of patient, parent or representative)

Late Cancellation & Missed Appointment Agreement

Please provide 24 hours advance notice of any changes or cancellations.

Appointments that are missed/rescheduled/cancelled with less than 24 hours notice will be billed $40.

Signature: _____ Date:_____

HIPAA Privacy Practices Acknowledgement Form

Due to new HIPAA compliance statutes, we as a healthcare provider are required to provide you with a Notice of Privacy Practices that describes your rights as a patient and must document that every patient or client has read and received it. The form is found on our website and is available at our center for you to read and take home with you.

By Signing below, I acknowledge the receipt of the Notice of Privacy Practices at Union Center For Healing Integral, PLLC.

Printed Name_____Signature _____ Date_____

(Of patient, parent or representative)

Communication Consent

We are required (UCFH and the individual provider) to have your consent to communicate via Email, Fullslate (online scheduling) and Text. At this time the emails, text and Fullslate are not encrypted. We are able to communicate with you by each of these forms but need your consent to do so. If you have sensitive health care information you wish to share through email, contact your provider first so we can send an encrypted message.

I consent to communicate by email, text, and Fullslate: Yes _____ No _____