Fertility Massage Intake Form

Name: _____ Phone Number: _____

Address: _____ City, State, Zip_____

Birthday: _____ E-mail: _____ Occupation: _____

☐ Check the box to NOT be signed up for The Metta Center's monthly e-newsletter

Who can we thank for referring you? (Specify friend, website or other source) _____

MEDICAL BACKGROUND

What stress reduction/exercise activities do you engage in? _____

Do you have any of the following?

□ Arthritis □ Asthma □ Blood Clots □ Bursitis □ Cancer □ Cold/Flu Symptoms □ Diabetes □ Fibromyalgia
□ Headaches □ Heart Conditions □ High Blood Pressure □ Infections □ Neck/Back/Spine Condition □ Osteoporosis
□ Skin Disorders □ Surgeries (please list below) □ TMJ Syndrome □ Ulcers □ Varicose Veins

Comments/Other Conditions not listed: _____

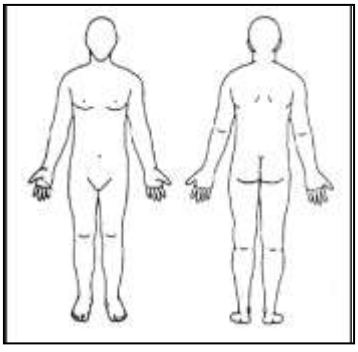
List any & all past accidents & surgeries: _____

List any medications/supplements that you are taking: _____

MASSAGE BACKGROUND

Have you ever received a professional massage? _____ If yes, what type: _____
Are you allergic/sensitive or dislike any oils or creams? ____ If yes, what type: _____

Mark areas of pain with an X
Mark where you had surgery with an O



List specific areas of the body for Pain Relief work:

_____

Depth of pressure preferred (circle): Light Medium Strong Extra Strong

*Therapeutic Massage may include work on the scalp, face, feet, and glutes.
(Abdominal and/or Breast Massage is only performed on request)

List any areas of the body that you would prefer not to be worked on:

_____

Office Use Only: ☐ Vagaro: General Info ☐ Vagaro: Health History ☐ Added to Mailchimp ☐ Referral email sent ☐ Scanned to computer

FERTILITY SPECIFIC QUESTIONS

Number of Pregnancies:_____ Number of Births:_____ Any Miscarriages?:_____

How long have you been actively trying to conceive? _____

Are you seeing a Fertility Specialist? If so, who and for how long? _____

Have you and your partner been tested for hormonal levels and sperm motility/count? (List results)_____

_____

Are you seeking out and are open to other alternative therapies? This would include herbal medicine, acupuncture and chiropractic_____

Is your partner open to receiving fertility massage? _____

Date of first day of last menstruation?: _____

Are your cycles regular? _____ Do you know when you ovulate? _____

How is your diet and are partners diet? _____

What do you think is inhibiting conception? Hormones, Timing, Age, Diet, Lifestyle? _____

Please read & initial in the following paragraph:
I understand that therapeutic massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment. ___(Initial) Because therapeutic massage/bodywork should not be performed under certain circumstances, I affirm that I have stated all medical conditions of which I am aware and will inform my practitioner of any changes in my medical status. I understand that immediate termination of this session will take place in the case of illicit sexually suggestive remarks or advances from the client, and I will be liable for the full payment of the scheduled appointment. ___(Initial) If I am unable to make a scheduled appointment, I agree to cancel before 4:00 PM the day before my scheduled appointment. If I do not cancel before 4:00 PM the day before, I agree to the cancellation policy and subsequent fee. ___ (Initial)

Signature: _____ Date: _____