Structural Healing Massage
and Bodywork, Inc.
3758 SE Milwaukie Avenue
Portland, OR 97202

Maya Abdominal Therapy
Confidential Client Intake Form

Date of initial visit _____ Date of Birth _____
Name _____
Address _____
Phone _____ email _____
Referred by _____

Primary concern or reason for seeking my care _____
_____
_____
_____

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? _____
Does it interfere with work? _____ sleep? _____ recreation? _____ other? _____

What other therapies have you used? _____
_____

What types of bodywork have you experienced? _____
_____

Medical History:

What were your athletic or physical activities growing up? _____
_____

Please describe any falls, accidents or injuries especially to your sacrum or tailbone including your age at the time _____
_____
_____

List any surgeries including your age at the time _____
_____
_____

Are you currently experiencing any pain, soreness or particular tension in your body? Where?

When did it start?
What makes it better?
Worse?

Do you have urinary issues? UTIs or incontinence?
Vaginal infections? Yeast or BV?
Other STDs? Herpes or HPV?

Are you under the care of another healthcare provider? Please provide name(s) and specialty (eg: acupuncture, chiropractor)

Please list medications and supplements you are taking

Do you smoke tobacco or marijuana?

Any other medical conditions I should be aware of?

Diet and Digestion:

Do you follow any particular dietary practices?
Do your diet and your eating habits serve you well?

Do you have any food allergies or sensitivities?

Describe your typical
Breakfast
Lunch
Dinner
Snacks
Water intake Other beverages?

What are your favorite foods?
Your food weaknesses?

Have you ever struggled with an eating disorder?

Do you use caffeine? What kind and how much?

Alcohol? Same questions.

Do you experience bloating, gas or burping after eating? What foods trigger this? _____

How often are your bowel movements? _____

Do you ever experience diarrhea, constipation or pain with bowel movements? _____

Reproductive Health

Age at 1st menses _____ what was this like for you? _____

Length of cycle _____ how many days do you bleed? _____
Is the blood generally red and fresh? _____

How do you track your cycles? _____
1st day of your last period _____

please check any that apply

painful periods use pain scale 1-10		painful intercourse	
irregular cycles		polyps or cysts? location	
amenorrhea		fibroids? location	
heaviness in pelvis prior to menses		vaginal dryness	
excessive bleeding		endometriosis	
dark or brown blood Beginning or end of cycle		headaches	
clots		varicose veins	
water retention/bloating		hemorrhoids	
painful ovulation		sciatic pain	
other		irregular pap	

Do you experience PMS? What is that like for you? _____

_____

What method of contraception do you use? _____

Have you experienced fertility challenges? _____

_____

Are you actively inviting a baby into your life? _____

Rate your interest in sex: high _____ moderate _____ low _____ none _____
Do you have difficulty experiencing orgasms? _____

Have you experienced sexual trauma? _____

Childbearing

Have you birthed any children? How many? _____
What are their names and ages? _____

_____

Describe your experience of
Pregnancy _____

_____

Labor _____

_____

Birthing _____

_____

Postpartum _____

_____

Miscarriages: please share approximate date(s) and gestation _____

_____

Abortions: please share approximate date(s) _____

_____

What do you know about your own birth? _____

_____

_____

_____

Family History

check any that apply to your mother, sisters, grandmothers or aunts

cancer - type		endometriosis	
menstrual problems		difficult menopause	
fertility challenges		age(s) at menopause	
fibroids		other	

Lifestyle & Emotional

Occupation _____ Marital/relationship status _____

What do you do for exercise? How often? _____

What do you do for fun? _____

What other self-care practices do you have? _____

What else do you enjoy about your life? _____

What is challenging? _____

Do you experience anxiety or depression? _____

How is your sleep? _____

What personal and health related shifts would you like to make or experience in the next 6 months? _____

In the next year? _____

Anything else I should know about you?

Menopause and Peri Menopause

if applicable to you

What are your feelings about being in this phase of your life? How would you describe your current relationship with your body? How is it different from 5 or 10 years ago? _____

_____

_____

_____

_____

_____

What are your concerns as you look forward? _____

_____

_____

_____

please check any that apply

hot flashes		flooding	
spotting		fatigue	
increased or decreased libido		depression	
vaginal dryness		anxiety	
painful intercourse		mood swings irritability	
insomnia or disturbed sleep		memory loss	
organ prolapse		other	

Age when symptoms began _____ Are they getting worse? _____ Better? _____ Same? _____

Have you used hormone replacement therapy? What kind and for how long? _____

_____

Have you used anything else to help manage symptoms? _____

_____

Is there other support that you need? _____