KINDRED SPIRIT

Women Wellbeing and Massage Therapy

CLIENT INFORMATION & CONSENT FORM FOR TREATMENTS WITH DIANE PRZYBILLA

PERSONAL DETAILS

FIRST NAME

LAST NAME

ADDRESS

POSTCODE

EMAIL

PHONE NUMBER

DATE OF BIRTH

AGES OF CHILDREN

MARITAL STATUS

REASON FOR YOUR VISIT

WHAT IS YOUR PRIMARY CONCERN?

WHEN DID IT FIRST OCCUR?

DESCRIBE ANY STRESS OCCURRING AT THE TIME OF ONSET

IS THIS CONDITION INTERFERING WITH

SLEEP

WORK

RELATIONSHIPS

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MENSTRUAL AND FERTILITY CONDITIONS

- [ ] PAINFUL PERIODS
- [ ] PAINFUL OVULATION
- [ ] IRREGULAR PERIODS
- [ ] EXCESSIVE BLEEDING
- [ ] POLYCYSTIC OVARIAN SYNDROME
- [ ] POLYCYSTIC OVARIES
- [ ] FIBROIDS
- [ ] ENDOMETRIOSIS
- [ ] PREMATURE OVARIAN FAILURE
- [ ] FAILURE TO OVULATE
- [ ] LOW AMH
- [ ] MISCARRIAGE (ONCE)
- [ ] RECURRENT MISCARRIAGE

SYMPTOMS EXPERIENCED PRIOR TO AND DURING MENSTRUATION

- [ ] LOWER BACK PAIN
- [ ] HEADACHES
- [ ] DIZZINESS
- [ ] CHANGE IN BOWELS
- [ ] PAINFUL/NUMB IN LEFT LEG
- [ ] PAINFUL/NUMB IN RIGHT LEG
- [ ] DARK THICK BLEEDING
- [ ] BLOOD CLOTS
- [ ] CRAMPS LEFT SIDE
- [ ] CRAMPS RIGHT SIDE
- [ ] CRAMPS CENTRE LOWER ABS
- [ ] HEAVINESS OR PRESSURE

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CONTINUED

- [ ] DRAGGING SENSATION
- [ ] INCREASED URINATON

SYMPTOMS CURRENTLY EXPERIENCING

- [ ] VARICOSE VEINS LEFT LEG
- [ ] VARICOSE VEINS RIGHT LEG
- [ ] BLADDER INFECTIONS
- [ ] BLADDER WEAKNESS
- [ ] FREQUENT URINATION
- [ ] DIFFICULTY EXPERIENCING ORGASMS
- [ ] COLD HANDS OR FEET
- [ ] TROUBLE WITH SLEEP ONSET
- [ ] ANXIETY OR DEPRESSION
- [ ] TIGHTNESS IN CHEST
- [ ] TROUBLE WITH SLEEP MAINTENANCE
- [ ] DIFFICULTY BREATHING INTO ABDOMEN

DIGESTIVE COMPLAINTS

- [ ] CONSTIPATION (<1 PER DAY)
- [ ] DIARRHOEA
- [ ] IBS
- [ ] FORMED BOWEL MOVEMENTS (SAUSAGE LIKE)
- [ ] LOOSE BOWEL MOVEMENTS
- [ ] HARD BOWEL MOVEMENTS
- [ ] NON-FORMED MOVEMENTS (PELLETS)
- [ ] ABDOMINAL PAIN (LEFT/RIGHT)

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MEDICAL HISTORY

ARE YOU UNDER TREATMENT FOR INFERTILITY I.E. IVF Y ☐ N ☐
DETAILS:

HAVE YOU HAD SURGERY ON YOUR ABDOMEN/LOWER BACK? Y ☐ N ☐
DETAILS:

ACCIDENTS OR TRAUMAS Y ☐ N ☐
DETAILS:

FALLS OR INJURIES TO SACRUM, TAILBONE OR HEAD? Y ☐ N ☐
DETAILS:

RECENT PROCEDURES <6 MONTHS) Y ☐ N ☐
DETAILS:

HIGH OR LOW BLOOD PRESSURE Y ☐ N ☐
DETAILS:

OTHER RELEVANT MEDICAL CONDITIONS Y ☐ N ☐
DETAILS:

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MENSTRUAL & PREGNANCY HISTORY

AGE OF MENARCHE (PERIOD) & EXPERIENCE

DETAILS:

NUMBER OF PREGNANCIES

NUMBER OF DELIVERIES

DATES OF EACH BIRTH

METHOD OF DELIVERIES

DETAILS:

IF YOU HAVE GIVEN BIRTH WHAT WAS YOUR EXPERIENCE OF:

PREGNANCY

LABOUR & DELIVERY

POST PARTUM

WHAT ARE YOUR FEELINGS TOWARDS BIRTH

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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?

HAVE YOU WITNESSED OR EXPERIENCED

EMOTIONAL ABUSE ☐

PHYSICAL ABUSE ☐

IN A CHILDHOOD? ☐

AS AN ADULT? ☐

WHAT CHANGES WOULD YOU LIKE ACHIEVE IN THE NEXT 6 MONTHS?

WHAT CHANGES WOULD YOU LIKE TO ACHIEVE IN THE NEXT 12 MONTHS?

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OTHER COMMENTS

PLEASE USE THIS SPACE TO GIVE ANY FURTHER RELEVANT INFORMATION THAT YOU FEEL WOULD BE BENEFICIAL FOR ME TO KNOW PRIOR TO YOUR TREATMENT