

# 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?

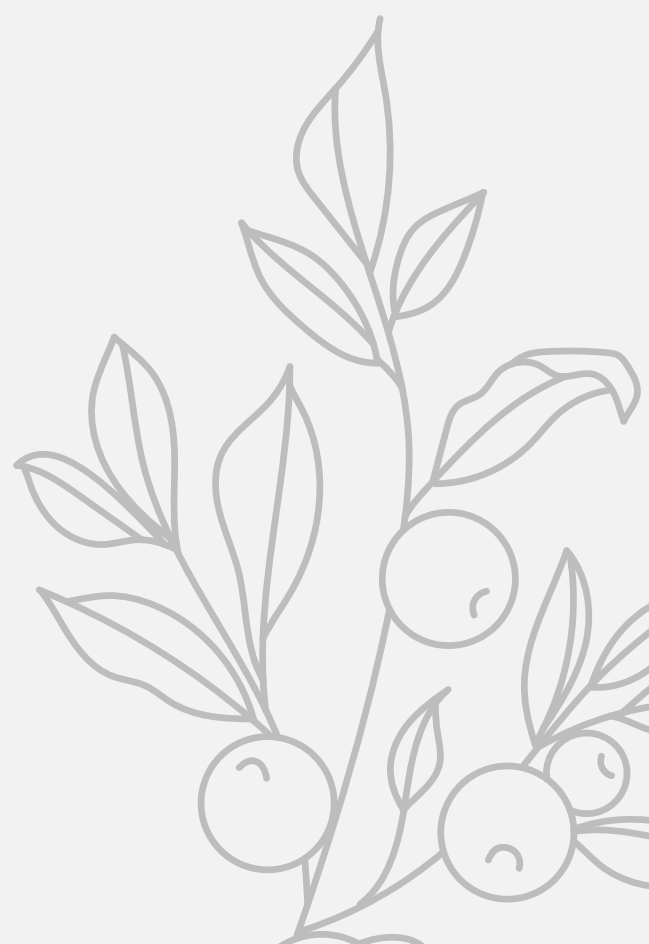
DESCRIBE ANY STRESS OCCURRING AT THE TIME OF ONSET

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 URINATION

## 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

IN A CHILDHOOD?

PHYSICAL ABUSE

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

