*Subliminal Bliss*

Name:_____ Date of visit:_____

Phone:_____Email:_____

Date of Birth:_____ Age:_____Occupation(s): _____

Emergency Contact Name and Phone: _____

How'd you find me?_____ Would you like to join my mailing list?_____

Primary reason for your consult today? _____

_____

Please list your symptoms, Issues and / or concerns.

_____

_____

Have you had massage/bodywork before?_____

Do you have any areas of chronic pain or tension in your body?_____

Areas you want extra attention on? _____

Areas to avoid/be cautious around? _____

Are you sensitive to incense smoke? _____

Favorite scents? _____ Scents you dislike?_____

Are you currently under the care of another healer/ health care provider(s)? If so what/who?

_____

Please list your current medications and /or supplements, herbs, remedies:

_____

Do you have allergies (Medicines, foods, airborne, topical/skin, herbs, plants etc.)?_____

Please specify allergen and reaction:_____

_____

Falls/Injuries to Sacrum/head/tailbone (age you were and describe)

_____

Any low back or hip pain, tension or injuries? _____

Any surgeries, major illnesses, accidents, hospitalizations or traumas in your lifetime? Please include your age at the time, description and any way it is still affecting you today.

_____

_____

**YOUR WOMB STORY**

When was your first menstruation?_____How was it for you? _____

_____

Date Last Menstrual Period began :_____

Average monthly length of cycle?_____ How many days do you generally bleed?_____

Have your cycles ever been 27 days or shorter? _____

Please describe your monthly menses (color of blood, amount, patterns of flow, sensations, pain?)

_____

_____

Any Emotions? PMS? Breast tenderness? Bloating? Fatigue? Relief when bleeding starts? Cramping? Thoughts? Discomforts? Dreams? Cravings? etc.

_____

_____

Do you use tampons, pads, organic and bleach free products, period panties, cup, etc?

_____

_____

What methods of contraception have you used in the past? _____

_____

What method are you using currently?_____

Last Pap smear date _____Results _____

Are you actively trying to get pregnant?_____ Do you chart your cycles?_____

If you chart your cycles, do you watch them in relevance to the moon? _____

Do you know when or if you ovulate?_____

Do you have a history of sexual abuse or trauma that you would like to share?_____

_____

_____

Did you undergo counseling or other healing for this? Did it help? _____

_____

Write P next to any other symptoms below you have experienced in the past and N if experiencing now:

___ Painful Periods
___ Irregular cycles
___ Heaviness in Pelvis prior to menses
___ Constipation prior to menses
___ Dark Thick Blood at ___ Beginning ___ End ___ Both
___ Excessive Bleeding of one pad or more per hour
___ Endometriosis
___ PMS
___ Fibroids
___ Uterine or Cervical Polyps
___ Uterine Infection(s)
___ Vaginitis
___ Cysts
___ Bladder Infection(s)
___ Urinary Incontinence
___ Frequent Urination
___ Painful Intercourse
___ Vaginal Dryness
___ Vaginal itching or burning
___ Mal odored or colored vaginal discharge i.e thick, clumpy, yellow, green, etc.
___ Yeast infections
___ Herpes
___ BV/ Bacterial Vaginosis

___ Uterine bladder or rectal prolapsed
___ Pessary
___ C sections
___ Abdominal surgeries
___ Spotting at beginning, end or in-between periods?
___ Episodes of Amenorrhea (no period) When? How long?
___ Two periods a months. When? How long?
___ Spontaneous bleeding. When? How long?

Explain any checked above_____

_____

**PREGNANCY HISTORY**

Number of Pregnancies: _____ Number of Children: _____

Miscarriages: _____Terminations:_____

Complications:_____

Do you know of any complications your mothers, sisters or grandmothers experienced? With pregnancy, fertility or their menstrual cycles?

_____

_____

Are you peri menopausal or post menopause?_____

If so, how is your experience _____

_____

**CURRENT GENERAL WELL BEING**

Describe your general emotional & Spiritual state

_____

If possible, please describe the most negative emotion you experience.

_____

When do you most often feel this emotion?:_____

Is there anywhere in your physical body you particularly notice this emotion reside?_____

_____

Do you have Any of the following concerns? **Please write P for past and N for now**

___ Anxiety
___ Panic Attacks
___ Grief Process
___ Depression
___ Codependence
___ Relationship problems
___ Experienced abuse
___ Substance abuse
___ other addictions

Have you sought support in the past or currently for any of these concerns? And if so is/has it

helped?_____

Are you happy with your relationship with food? _____

_____

_____

How is your digestion?_____

_____

What is you diet like? _____

Describe your exercise routine (type, frequency)? _____

_____

What changes would you like to achieve in 6 months? _____

_____

One Year?_____

_____

Are you seeking a treatment plan? If so, what's most important to you? Your limitations an desires?

_____

_____

Feel free to share any additional Information you feel is important for your practitioner to know :

_____

_____

**Client Confidentiality and Release Agreement**

I understand that all modalities offered by Abby Kenny are not replacements for medical care. The practitioner, a licensed massage therapist, does not diagnose or treat mental or physical illness, disease or other physical or mental conditions. As such, the practitioner does not prescribe medicines, nor does she perform spinal manipulations. By choosing to work with Abby Kenny, It is my, the client's responsibility to consult the appropriate licensed health care professionals for treatment of any mental or physical disease, symptoms or concerns that I may have. I agree to take responsibility for my own health and my own response to massage therapy and I agree not to hold the massage therapist responsible for any unwanted results in my life after receiving a massage from her. The practitioner may recommend referral to a qualified physical or mental health care professional for any physical or emotional conditions I may have that are out of her scope of practice. The practitioner may recommended self care routines that may regard food, flower essences or herbal practices and it is up to you to research and decide what is suitable for you. By signing this you acknowledge that it is your responsibility to check with your doctor to verify what it is suitable for you and you will not hold Abby Kenny or Subliminal Bliss responsible for any unwanted results. I have stated all my known physical and mental conditions and take it upon myself to keep the massage therapist updated on my health status. The information I provided in this form is accurate and true to the best of my knowledge. **Missed appointments without 24 hour notice are subject to the cost of the appointment that was missed.**

**Please sign to confirm you have read and agree to the above terms and conditions.**

Client Signature: _____Date: _____

Practitioner signature:_____Date: _____