Rising Moon Medical Massage

ABDOMINAL MASSAGE INTAKE FORM

Personal Information

Name _____ DOB _____ Age _____

Address _____

City _____ State _____ Zip _____ Occupation _____

Cell Number _____ Referred by _____

Email address _____

Initial	Office Policies
	I understand that payment is due at the time of service.
	I agree to give at least 48 hours notice of cancellation of appointment or pay for my appointment time in full. Payment for late cancellations or missed appointments is patient responsibility and is due in full before rebooking missed appointments.
	I agree to inform my therapist of any changes to my health/vaccination history.
	This is a natural scent-only office. Please do not wear cologne, aftershave, or perfume to your appointment. It does not wash out of my linens and you will be charged replacement cost.

I, (name)_____ give my permission, for my therapist/practitioner to take notes about me, including health history/medical and/or personal information that I choose to disclose.

This information may be shared with my surgeon/doctor for the purpose of providing coordinated and optimal care.

I understand this information may also be used to contact me for the purpose of scheduling appointments and may be shared with employees of Michelle Rankin and Rising Moon Massage as needed for the purpose of my massage treatment plan.

In addition, Michelle Rankin may communicate with me about my appointments via text at the number above and via email at the address above.

Signature _____ Date _____

660 Jadwin Ste C. Richland
risingmoonmassage@proton.me | Phone 509.947.1751 | Fax 509.984.6616

What's the reason for your visit?

Primary reason for this visit?

What would you like to achieve as a result of your visit?

When did you first notice this?

Do you feel something may have triggered this?

Describe any stressors occurring at this time?

What makes you feel better?

What makes you feel worse?

What changes or goals would you like to achieve over the next 3/6 months?

A Little bit of History

Are you taking any of the following – medication, supplementation, natural remedies?
If so, please give details:

Do you use alcohol or recreational drugs? If so, how regularly and how do you feel about this?

Do you smoke? If so, how regularly and how do you feel about this?

Any allergies? If yes, what are you allergic to? What reaction do you have?

Have you experienced any of the following? If so, please share some details.

Surgery

Accidents

Injuries to sacrum/head/tailbone

Concerns

Do you, or have you ever suffered from any of the following:

- ☐ Headache
- ☐ Asthma
- ☐ Cold hands/feet
- ☐ Swollen ankles
- ☐ Sinus conditions/colds
- ☐ Seizures
- ☐ Skin conditions
- ☐ Lower back pain
- ☐ Sciatica
- ☐ Herniated/bulging discs
- ☐ Painful/swollen joints
- ☐ Neck/shoulder/jaw tension
- ☐ High/low blood pressure
- ☐ Sore heels when walking
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep disturbance
- ☐ Feeling faint
- ☐ Varicose veins
- ☐ Cancer (type)
- ☐ Haemorrhoids
- ☐ Numb feet on standing

Family Story

Please share any significant details of your birth family story if known; this may include physical or mental health, lifestyle, cause/age of death of your parents and any other details you feel are relevant.

Maternal

Paternal

Gut Health

Describe your relationship with food?

What were mealtimes like growing up?

What are mealtimes like now?

Do you have any food intolerances or allergies?

Do you follow a particular diet?

Do you eat home cooked food? ☐ Mainly ☐ Occasionally ☐ Never

What is your typical daily intake of the following?

Water Caffeine Alcohol

Do you experience any bloating, burbs or flatulence after eating? ☐ Yes ☐ No

If so, what triggers this?

How often are your bowel movements?

Do you suffer from abdominal pain, constipation, diarrhea, incomplete bowel movements, thin stools, blood or mucus in your stools?

Mental & Emotional Health

How do you nurture yourself?

Where and how do you find joy?

Are you currently experiencing stress?

How do these affect your life and how do you manage them?

Do you have a faith or spiritual practice and if so, would you be willing to share this?

What exercise do you enjoy, and how often do you do it?

Do you experience low mood, anxiety, depression, post-traumatic stress disorder, or any other mental health condition that you are willing to share?

Have you experienced any traumatic events that you would be willing to share?

Have you considered seeking professional support?

Pelvic Health

Do you experience pelvic pain or congestion? ☐ Yes ☐ No

If so, how does this affect you?

Do you experience pain in any of the following areas?

- ☐ Uterus
- ☐ Ovaries
- ☐ Vagina
- ☐ Vulva
- ☐ Penis
- ☐ Prostate
- ☐ Testicles
- ☐ Rectum
- ☐ Pain during sex
- ☐ Perineum

Do you experience any of the following urinary issues? If so, how does this affect you?

- ☐ Incontinence – coughing, jumping
- ☐ Overactive bladder
- ☐ Night time urgency
- ☐ Cystitis
- ☐ Incomplete bladder emptying
- ☐ Constant leakage
- ☐ Interstitial Cystitis
- ☐ Kidney Stones
- ☐ Bladder cancer
- ☐ Bladder prolapse
- ☐ Bladder stones

Have you had any pelvic tests – PAP, PSA or STD?

Have you ever had abnormal results? ☐ Yes ☐ No

If so when, and did you receive treatment?

Do you currently/have you use/used birth control? If so, please indicate which one and if hormonal, how long for:

- ☐ Pill
- ☐ Patch
- ☐ Diaphragm
- ☐ Injection
- ☐ Condoms
- ☐ IUD
- ☐ Abstinence
- ☐ Rhythm Method
- ☐ Fertility Awareness

Menstrual Health

Do you experience any of the following:

- ☐ Painful periods
- ☐ Absent period
- ☐ Lower back pain before/ during/after bleeding
- ☐ Irregular cycles
- ☐ Heaviness prior to period
- ☐ Dark thick blood – start/end
- ☐ Excessive bleeding
- ☐ Clots
- ☐ Dizziness
- ☐ Bowel changes
- ☐ Headache/migraine
- ☐ Water retention
- ☐ Endometriosis
- ☐ Painful ovulation
- ☐ Irregular ovulation
- ☐ Lack of ovulation
- ☐ Bleeding/spotting during ovulation
- ☐ Premature Ovarian Failure
- ☐ Polyps – uterine/cervical
- ☐ Fibroids – location/size/number
- ☐ Cysts – location/size/number
- ☐ Incontinence- bladder/bowel
- ☐ Vaginal dryness
- ☐ Bloating

How old were you when you started menstruating?

What was this like for you?

How many days is your menstrual cycle?

How many days is your bleed?

Please include number of days spotting at beginning or end.

What menstrual products do you use?

Do you bleed through more than one tampon or pad per hour?

When was your last menstrual bleed?

How do you feel about your menstrual cycle?

Do you Chart your cycle?

If so how – App, Paper charts?

Do you know if your mother, sister or other close female relations have experienced any of the following issues?

- ☐ Infertility
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Cancer
- ☐ Menstrual issues
- ☐ Menopause issues

Urogenital Health

Do you experience or have a history of any of the following:

- ☐ Painful/burning on urination
- ☐ Urinary retention
- ☐ Urinary incontinence or dribbling
- ☐ Difficult to start urination
- ☐ Weak/interrupted urine flow
- ☐ Frequent bladder infections
- ☐ Blood/pus in urine
- ☐ Pelvic pain/pressure
- ☐ Night time urination
- ☐ Pain/discomfort in -
- ☐ Testicles
- ☐ Penis
- ☐ Rectum
- ☐ Inner Thigh
- ☐ Pelvic Floor/perineum
- ☐ Erection pain/problems
- ☐ Lower back pain especially after sex
- ☐ Changes in sex drive
- ☐ Prostate disease or cancer
- ☐ Pelvic injury or surgery
- ☐ Sperm related fertility issues
- ☐ Vulvodynia
- ☐ Cystitis
- ☐ Interstitial cystitis
- ☐ Herpes
- ☐ HPV
- ☐ Bartholin's cyst

Desire & Libido

Do you enjoy making love?

Do you climax?

Are you satisfied with your level of sexual desire?

Have you noticed any changes recently?

How do you feel about this?

Fertility & Pregnancy Health

Are you hoping to conceive?

If so, how long have you been trying?

Have you or your partner had any pregnancies? ☐ Yes ☐ No

If so, did you choose to continue with them and what were they like?

Have you experienced any loss?

Have you given or witnessed birth?

If so what was the experience like?

How was your postpartum experience?

Have you had any fertility tests e.g. Sperm or egg reserve?

Are you under the care of a fertility specialist?

Please describe any treatment you may have received including - IUI, IVF, ICSI, Hormone treatment or Surgery.

Peri/Menopause Health

How do you feel about your menopausal journey?

What stories do you carry?

What positive menopausal role models do you have?

Are you keeping your menopausal journal?

Do you experience any of the following:

- ☐ Hot flushes
- ☐ Vaginal discharge
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Painful sex
- ☐ Insomnia
- ☐ Dry/itchy skin
- ☐ Dry/itchy vagina
- ☐ Vaginal Atrophy
- ☐ Spotting
- ☐ Flooding
- ☐ Tiredness
- ☐ Depression
- ☐ Anxiety
- ☐ Irregular menses
- ☐ Poor memory
- ☐ Mood swings
- ☐ Irritability

When did you start to notice symptoms?

Are these changing, increasing or decreasing?

Have you noticed a connection between your symptoms and:

- ☐ Diet
- ☐ Work Load
- ☐ Stress levels

Do you use, or have you ever used hormone replacement therapy or bio-identical hormones?

If so, which ones, and for how long?

Thank you for taking the time to share your information.

Is there anything else you would like to tell me?

Rising Moon Massage Waiver of Liability and Assumption of Risk

I understand that Massage, Manual Lymphatic Drainage, and Manual Therapy Services are for the purposes of stress reduction, pain reduction, relief from muscle tension, and support healing.

I have stated all of my known physical conditions, medical conditions, and medications to Michelle Rankin, and I will keep my massage therapist updated on any changes.

I understand that treatment with Michelle Rankin/Rising Moon Massage/Rankin Coaching, LLC is not a substitute for medical care and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.

Michelle Rankin does not diagnose medical illness, disease, or any other physical or mental conditions and nothing said during the session should be construed as such. Michelle Rankin does not prescribe medical treatment of pharmaceuticals, nor does she perform any chiropractic treatments or spinal manipulations.

If at any point during the Massage and/or Manual Therapy Service I am uncomfortable or uneasy with the treatment being administered and/or if I experience pain, I understand and hereby agree that it is my responsibility to immediately inform the massage therapist, so that the massage therapist may modify massage strokes and pressure to a level of comfort and/or terminate the Massage and/or Manual Therapy Services, if appropriate.

I voluntarily agree to assume all risks involved in receiving Massage and/or Manual Therapy. I give my consent for any Massage and/or Manual Therapy Services provided on the signature date of this document and for any future and past massage therapy sessions. I have read this document and hereby freely give my permission to be massaged and acknowledge and agree that I am doing so at my own risk. My health and safety with respect to all Massage and/or Manual Therapy Services are my sole responsibility. I acknowledge that my receipt of Massage and/or Manual Therapy Services from Michelle Rankin/Rankin Coaching, LLC/Rising Moon Massage may result in bodily injury to me. My decision to receive Massage and/or Manual Therapy Services from Michelle Rankin is voluntary, and I know, understand and assume any and all risks associated therewith.

By signing this document and in exchange for receiving Massage and/or Manual Therapy Services I, for myself and on behalf of my heirs, executors, administrators and personal representatives, hereby waive, release, discharge, and agree to hold harmless for any and all purposes, Michelle Rankin/Rising Moon Massage/Rankin Coaching, LLC, its members officers, employees, and agents from any and all liability for any and all injuries, including death, damages, claims, or demands relating to or resulting from the receipt of the Massage and/or Manual Therapy Services, now or in the future, foreseen or unforeseen.

I further agree to indemnify and hold Michelle Rankin/Rising Moon Massage/Rankin Coaching, LLC, its members, officers, agents, and employees, harmless from and against any and all claims, rights, damages, liabilities, losses, costs, and expenses (including court costs and attorney's fees) arising from or in connection with any injuries to me or other persons or damage to property caused by or attributed to me in connection with my receipt of Massage Services and/or Manual Therapy Services.

Client Printed Name _____

Client Signature_____ Date_____

Therapist signature_____ Date_____