KAREN TOWNSEND
holistic transformative bodywork

Certified H.A.R.T. Method Practitioner
Therapeutic Massage
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Holistic Abdominal Relief Therapy

Client Health History

FOR FEMALE ANATOMY

Your Menstrual Pattern:

_____ Painful periods

_____ Late, early, or irregular

_____ Dark, thick blood at onset or end of menstruation

_____ Dizziness with period

_____ Headache or migraine with period

_____ Excessive bleeding (more than one pad per hour)

_____ Blood clots during menstruation

_____ PMS/Depression with or before period

_____ Failure to ovulate regularly

_____ Painful ovulation

_____ Bloating or water retention with period

Do you experience heaviness in the lower pelvis **as menses begin**?_____

Do you experience heaviness in the lower pelvis **during ovulation**?_____

How many days does your period last?_____ Do you experience NO periods at all? _____

Explain _____

Have you experienced a period every two weeks within the past few years? _____

Have you taken hormone replacement therapy? _____If so, for how long?_____

Check other signs or symptoms that apply:

Varicose veins of the legs _____

Numb legs and feet especially when standing _____

Constipation _____

Low back ache _____

Cervical polyps _____

Tired weak legs _____

Sore heels when walking _____

Painful Intercourse _____

Hot Flashes _____

Mood swings _____

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Uterine polyps _____
Uterine fibroids _____
Frequent urination _____
Vaginal discharge _____ Color? How Often?_____
Vaginal yeast condition/vaginitis _____
Chronic miscarriages _____
Premature deliveries_____
Weak newborn infants _____
False Pregnancies _____
Difficult pregnancy "incompetent" uterus _____
Sexually transmitted disease_____
Cancer of the:
____ cervix ____uterus ____bladder ____ lower bowel

Memory loss _____
Depression _____
Bladder infections _____
Insomnia _____
Fatigue _____
Spotting _____
Pelvic inflammation _____
Ovarian or breast cysts _____
Endometriosis _____
Endometritis _____
Dry vagina without menopause _____

List any other symptoms not included on list: _____

_____

How many pregnancies have you had? _____ Number of deliveries? _____

Date(s) of deliveries ? _____How many children? _____

Were there any complications? _____

What was preganancy like for you? _____

Labor? _____

_____

Delivery? _____

_____

Did you nurse your babies? _____

If so, what was your impression of that experience? _____

_____

Have you had any pregnancy loss? _____Have you had any abortions? _____

If so, how many and when _____

What medications did ***your mother*** take when she was pregnant with ***you***? _____

_____

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Do any of the women on your mother's side of the family suffer from any of the following:

Fertility issues ____ Menstrual problems ____ Difficult childbirth ____

Difficult menopause ____ Cancer ____ Heart trouble ____

Are you currently pregnant? _____ Are you hoping to become pregnant in the future?_____

Do you now or have you ever had fertility challenges? _____

Are you now or have you ever taken birth control pills? _____

When and for how long? _____ _____

If nay, what type of birth control methods do you ***currently*** use? _____

Have you ever used:

____ IUD ____ Essure ____ hormonal birth control ____ hormonal replacement therapy

Are you presently or have you recently been under a doctor's care for gynecological problems? Explain. _____

_____

Please list any serious falls or accidents in childhood or as an adult especially those that involved your tail bone, back, head, or any whiplash – please explain: _____

_____

Rate your interest in sex: ____ High ____ Moderate ____ Low ____ None

Do you have difficulty achieving orgasms? Explain. _____

Were you ever raped? _____ At what age did this occur? _____

Are you a survivor of incest? Have you undergone counseling for rape or incest? _____

What was that like for you? Did it help? _____

Supplements

Please list any supplement, herbs, vitamins, or natural products you are presently taking:

_____

_____

_____