KAREN TOWNSEND
holistic transformative bodywork

Certified H.A.R.T. Method Practitioner
Therapeutic Massage
Shiatsu
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Client Health History

Holistic Abdominal Relief Therapy

FOR MALE ANATOMY

Urinary Symptoms:

Circle and describe those symptoms as applicable:
painful urination bladder | kidney infections | frequent urination | incomplete urination

Nocturnal (night time) urination frequency, how many times per night? _____

Changes in urinary stream (describe flow, stream, strength of stream, color) _____

When did you first notice these symptoms? _____

Are they getting better or worse? _____

Describe _____

Reproductive Health History:

Circle and describe those symptoms as applicable:
Headaches (migraine, tension, cluster) | Numbness in legs/feet | Sore heels | Low back pain |
Anxiety | Irritability | Depression

Varicose veins _____ location _____

Symptom explanations: _____

Is there a history of back injury/trauma? _____

If so, describe _____

_____

When did you first notice these symptoms? _____

Are they getting better or worse? _____

Describe _____

Circle and describe as applicable:
difficulty obtaining an erection | painful ejaculation | difficulty maintaining an erection

Have you had a PSA test (Prostate Specific Antigen)? _____ Date _____

Results _____

Have you had a sperm analysis test? _____ Date _____

Results _____

Additional comments _____

_____

_____

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Client Health History

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History of sexually transmitted diseases? _____ when?_____

Type/treatment? _____

Family history of cancer? _____ type? _____

Relationship to you: _____

Family history of prostate disease? _____ type? _____

Relationship to you: _____

Rate your interest in sex:
HIGH | MODERATE | LOW | NONE

Do you have pain with orgasm? _____

Doyou have, or ever had, difficulty experiencing orgasms? _____

Have you every had a fall or injury to your low back, sacrum, tailbone? _____

Have you experienced a history of:

rape? _____

trauma? _____

incest? _____

If so, when? _____

Did you undergo counseling for this? _____

If so, did/do you find this helpful? _____

Fertility

Have you ever had a vasectomy? _____ Date_____

Have you had a vasectomy REVERSAL? _____ Date_____

What method(s) of birth control have you used?_____

Have you conceived in the past? _____

How long have you and your partner been trying to conceive?_____

Please check as applicable. *Do you:*

_____ wear tight fitting underwear or clothing?

_____ take steam baths, saunas, and/or whirlpools?

_____ spend time on machinery that would make the testicles hot?

_____ use SEAT warmers in the car/truck?

_____ have varicosities of the scrotum?

Please list any medications and or supplements you are currently taking or have taken within the last 3 months:

_____