ABDOMINAL-SACRAL MASSAGE

Confidential Client Consultation Form

Name:_____ Date of Initial Visit_____

Address_____

_____ Postcode_____

Contactable Phone No:_____ email:_____

Date of Birth_____ Age_____ Occupation_____

Marital status_____ Referred by_____

Are you having any massage/bodywork at the moment – what type?_____

What is your primary concern?

MEDICAL HISTORY

Are you currently under the care of another health care provider(s), if so, please give details:

Current Medications/Supplements/Remedies

Surgical History (year and type)

Accidents or Traumas

Falls/Injuries to Sacrum/head/tailbone (describe)

Birth Trauma if known

EMOTIONAL & SPIRITUAL

What is your opinion of yourself?

If possible, please describe the most negative emotion you experience

YOU DO NOT HAVE TO ANSWER THIS QUESTION:
Have you ever experienced or witnessed emotional or physical abuse

DIGESTION & ELIMINATION

Typical Breakfast:

Typical Dinner:

Snacks/Processed foods

Water Intake (glasses/day) Caffeine Alcohol

Do you experience bloating/gas/burps after eating? What foods trigger this?

How often are your bowel movements? Do your stools: sink/float

Do you ever suffer from constipation?

Circle any of the following you are *Currently* experiencing
Underline and of the following you have experienced in the *Past*

Ringing in Ears Pins and needles in arms, legs, hands or feet

Asthma	Cold Hands or Feet	Swollen ankles	Sinus Conditions	Seizures
Sciatica	Painful Joints	Swollen Joints	Spinal Problems	Anxiety
Fatigue	Trouble Sleeping	Loss of Memory	Depression	

Muscular Tightness: (location) Herniated or Bulging disc: (location)
High or Low Blood Pressure

MALE ~ REPRODUCTIVE HEALTH HISTORY
Circle and Describe those symptoms as applicable

Headaches: Migraine_____Tension_____Cluster_____ Low back pain Sore heels

Varicose Veins _____Location_____

Family History of Prostate Disease:_____Type_____Relationship_____

Family History of Cancer_____Type_____Relationship_____

History of sexually transmitted disease_____When_____Type_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Urinary Symptoms (*circle those applicable*)

Painful urination Bladder/Kidney infections
Frequent Urination Nocturnal Urination/ Frequency_____
Changes in urinary stream (describe flow, stream, strength of stream)_____

When did you first notice these symptoms_____

Are they getting better or worse_____Describe_____

Erectile Function(*describe as indicated*)

Difficulty obtaining an erection Difficulty maintaining an erection Painful ejaculation

Is there a history of back injury/trauma_____Describe:_____

When did you first notice these symptoms_____

Are they getting better or worse_____Describe_____

Results of PSA (prostate specific antigen) Test if known_____ Date done_____

Results of Sperm count (if applicable and known)_____Date done_____

Additional Comments: