Maya Abdominal Massage Confidential Intake Form
Nicole Kruck, LMT. 180 Riverside Blvd. #4U (212) 724-5386

Date:_____ Birthdate_____ Email :_____

Name:_____

Address:_____

_____

Phone:_____Alternative Contact #_____

Age:_____ Current weight_____ 1 Years ago_____3 Years ago_____

Married __Significant Other__Single__ Do you have children? #_____Ages_____

Are you currently in a relationship?_____

Present health concerns?_____

_____

_____

_____

_____

Onset and length of any symptoms_____

_____

At or around the time of onset were there other emotional stresses occurring?_____

_____

Number of pregnancies_____ If more than one, how far apart?_____
Number of deliveries _____
C-sections _____
What was your experience with pregnancy, labor and or delivery?_____

_____

Have you had any miscarriages _____ When?_____

Have you had any abortions _____ When?_____

If so, were there any complications?_____

_____

Current medical procedures:_____

_____

Have you ever had any abdominal, pelvic or back surgeries? (Explain)_____

_____

Any other surgical procedures_____

Serious Accidents_____

Do you have an IUD_____ Are you currently taking any birth control pills or

infertility drugs?_____

Are you currently taking any other medications?/ How long_____

_____

Childhood medical surgeries, accidents, falls or physical traumas_____

_____

_____

Did you take any medications as a child? _____How often_____

Have you ever gone for counseling? _____ For how long?_____

If so what is (or was) your experience? _____

_____

Please check your opinion of yourself :

	Lots	Some	A little
Faith			
Hope			
Humor			
Charity			
Spirituality			

Do you meditate or pray?_____ If so how often?_____

Have you ever done any guided visualization? _____

NUTRITION

	Do you	If so how much?	How often?
Smoke			
Drink alcohol			
Drink water			
Drink Caffeine (coffee, soda, tea)			
Exercise			
What type?			

What does a regular meal consist of?

Breakfast_____

Lunch_____

_____

Dinner_____

_____

How long has this been your current diet? _____

How many times a week would you usually consume the following foods?

Meat_____ **Take-out**_____**Raw foods**_____
Chicken_____ **Candy** _____**Soy Product**_____
Dairy_____**Range-Free**_____**Fish**_____
Frozen Foods_____**Fresh Fruit**_____ **Desserts**_____

Do you ever buy organic foods?_____**If so what and how often?**_____

What food are you most likely to binge on? _____**How often?**____

How often do you cook at home?_____

Do you have any food allergies?_____

DIGESTION/ ELIMINATION

Rate your digestion_____**excellent**_____**fair**_____**poor**

Do you often feel tired after a meal?_____**Do you ever feel bloated?**_____**Gas?**___

Do you eliminate at least once a day?____**If not how often?**_____

Do your stools normally sink ____or float____?

Do you ever experience frequent urination?_____

FAMILY HISTORY

Is there history of any of the following problems among the women in your family?

Cancer__ Edometreosis___ Fibroids&Cysts___ Early or Difficult Menopause____

Infertility___ Menstrual Problems____ Difficult Childbirth or Pregnancy_____

Do you know if there were any complications with your birth?_____

_____

REPRODUCTIVE CYCLES

How often do you menstruate?_____

Do you have irregular menstrual cycles?_____ If so, how long has this been happening?_____

Do you have exceptionally light or heavy periods(a pad or tampon more than every 4 hours) clots?___Explain?_____

How many days long does your menstrual cycle last?_____

Do you spot between periods? Or have any unexplained bleeding?_____

Has there been any changes in your periods this past year?_____

Are you experiencing any menopausal symptoms?_____If yes please check

hot flashes____ insomnia_____ irregular menses_____ fuzzy memory____

PERSONAL

What is you opinion of yourself (how would you describe yourself to someone else)?

_____

_____

How was your relationship with both parents growing up?_____

_____

What is your current relationship with both your parents?_____

_____

_____

Is your current love life satisfying?_____

_____

_____

How would you rate your sexual desire? __High __Moderate __Seldom

Do you usually experience orgasms ? ___Always ___Sometimes ___Never

Have you ever been sexually abused?_____

Do you have any unrealized longing in life? _____

_____

What type of hobbies or activities do you like to participate in?_____

_____

Do you have any of the following please check the box in front;

__high blood pressure __ asthma __ heart problems __skin rashes

___ skin fungus __anemia __urinary, kidney or bladder infections __std's

__broken or dislocated bones ___compromised immune system ___allergies

__diabetes ___fainting spells ___hepatitis ___emotional problems ___

Have you ever participated in any of the following for more than 6 months time?

___Running on hard surfaces ___High impact aerobics ___Horseback ridding
___Gymnastics ___High impact dance ___

Please check any of the following symptoms that pertain to you.

___Painful periods ___Dark blood at onset or end of menses
___Late, early or irregular periods ___Headaches or migraines w/periods

___Dizziness w/periods
___Varicose veins
___Tired, weak or numb legs
___Sore heels when standing or walking
___Uterine fibroids
___Uterine polyps
___Intense PMS/depression before period
___Frequent urination
___Chronic constipation
___Blood clots during menstruation
___Difficult pregnancies or deliveries
___Painful intercourse
___Dry vagina with or w/o menopause
___Pelvic inflammation
___Vaginal discharge (what color)
___Cancer of the uterus, cervix, vagina, fallopian tubes, bladder, or intestines

___Painful ovulation
___Poor circulation in feet
___Especially when standing
___Chronic low back pain
___Endometritis
___Endometriosis
___Frequent yeast infections-vaginitis
___Uterine infections
___Bladder infections or cystitis
___Premature deliveries
___Infertility
___Difficult menopause
___Ovarian or breast cyst
___Pregnant

Please list any other symptoms not on this list_____

_____

Is there anything else you would like to add?_____

_____

Thank you for completing this information to the best of your ability. Please bring this with you to your appointment and we will go over this form together. I look forward to working with you.

Sincerely,
Nicole Kruck, Lmt.