Women 2 Women
Restorative Therapy

Women's Health Intake

GENERAL INFORMATION Today's Date _____

Last Name _____ First Name _____ MI _____

Would you prefer to be called by another name? _____

If under the age of 18, name of Parent/Guardian _____

❒ Male ❒ Female Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Work Phone _____ Occupation _____

E-mail Address: _____

❒ I prefer to receive appointment confirmations via email.

❒ I prefer to receive appointment confirmations via text messaging. Cell phone carrier _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____ ❒ Cell ❒ Home ❒ Work

How did you hear about Women 2 Women Restorative Therapy? Check all that apply.

- ❒ Referring Health Practitioner (Name: _____)
- ❒ W2WRT Client or Staff (Name: _____)
- ❒ Event (Which Event? _____)
- ❒ Newspaper/Magazine Ad (Which Ad? _____)
- ❒ Internet (Referring website or Search engine? _____)
- ❒ Other _____

24 HOUR CANCELLATION POLICY

We look forward to serving you and all our clients. Please be advised that last minute cancellations and “no shows” prohibit other clients from utilizing our services.

I understand that in the event that I do not give 24 hours notice of cancellation, except in the case of emergencies, I will assume responsibility for payment of the full fee. Likewise, when Women 2 Women Restorative Therapy personnel cancel appointments with less than 24 hours, except in the case of emergencies, your next session will be fully covered.

Similarly, being late for a session compromises the level of service rendered by creating sessions that cannot be properly completed, along with added stress.

I understand that when I am late for a session, I will receive whatever time is remaining if a partial session is possible. If Women 2 Women Restorative Therapy personnel are late, we will do our best to provide for a full treatment at your scheduled time. In the event that a full treatment is not possible, compensation will be provided.

_____

Print Name

_____

Signature

_____/_____/_____

Date

Your understanding is greatly appreciated.

GENERAL HEALTH HISTORY

Are you currently under the care of a Health Care Practitioner for your concerns? ❑ Yes ❑ No

If yes, please give name(s) and location(s). _____

List known allergies (including latex): _____

Explain any of the following. Include **year** and **treatment received**.

Surgical procedures: _____

_____

_____

Major illnesses and hospitalizations: _____

_____

_____

Injuries/Accidents (Recreational, Auto, Work-related, Falls, etc.): _____

_____

_____

List all current medications (including regular use of over-the-counter meds). Use back if necessary.

Medication	For treatment of	Amount	Effectiveness

List current vitamin, mineral, or herbal supplements, homeopathic preparations, or essential oils.

_____

_____

_____

CURRENT WOMEN'S HEALTH CONCERN

What concerns, issues, problems, or pain motivated to you seek care? Please describe below. Use the back if you need additional room. _____

_____

_____

_____

_____

What do you think is causing or contributing to these symptoms? _____

_____

Is there an event that you associate with the onset of these symptoms? ❑ Yes ❑ No If "YES," please describe.

_____

What is the frequency of your symptoms? ❑ Constant ❑ Off/On ❑ Cyclic ❑ Infrequent

Are they ❑ Getting Better? ❑ Staying the same? ❑ Getting Worse?

How long have you been experiencing these symptoms? _____ years _____months

What types of treatment / providers have you tried in the past for these concerns?

❑ Acupuncture	❑ Family Practitioner	❑ Nutrition / diet
❑ Anti-seizure medications	❑ Herbal Medicine	❑ Physical Therapy
❑ Antidepressants	❑ Homeopathic medicine	❑ Psychotherapy
❑ Biofeedback	❑ Lupron, Synarel, Zoladex	❑ Psychiatrist
❑ Botox injection	❑ Massage	❑ Rheumatologist
❑ Contraceptive pills	❑ Meditation	❑ Skin magnets
❑ Danazol (Danocrine)	❑ Narcotics	❑ Surgery
❑ Depo-provera	❑ Naturopathic care / medication	❑ TENS unit
❑ Electrical implant	❑ Nerve blocks	❑ Trigger point injections
❑ Gastroenterologist	❑ Neurosurgeon	❑ Urologist
❑ Gynecologist	❑ Nonprescription medicine	❑ Other _____

The questions on the following pages may or may not be relevant to your foremost health concerns. If they are not relevant, please leave those answers blank and answer only those questions you believe to be pertinent.

The questions on the following pages are intended to assist your clinician with the initial assessment. They are not intended as a diagnostic tool. If you have questions or concerns about whether to seek additional medical evaluation, please discuss this with the intake clinician.

MENSTRUAL HISTORY

How old were you when your menses started? _____

Are you still having menstrual periods? ❑ Yes ❑ No

Answer the following only if you are still having menstrual periods.

Periods are: ❑ Light ❑ Moderate ❑ Heavy ❑ Bleed through protection

How many days between your periods? _____

How many days of menstrual flow? _____

Date of first day of last menstrual period _____

Do you have any pain with your periods? ❑ Yes ❑ No

Does pain start the day flow starts? ❑ Yes ❑ No Pain starts _____ days before flow

Are periods regular? ❑ Yes ❑ No

Do you pass clots in menstrual flow? ❑ Yes ❑ No

Check all those you experienced related to your menstrual cycle?

- ❑ Pain at ovulation (mid-cycle)
- ❑ Pain just before period
- ❑ Cramps with period
- ❑ Pain with period
- ❑ Pain after period is over

BREAST SYMPTOMS

Do you experience breast tenderness? ❑ Yes ❑ No If yes… ❑ Constantly? ❑ Cyclically?

Do you have fibrocystic breast tissue? ❑ Yes ❑ No Do you have nipple discharge? ❑ Yes ❑ No

Have you had the following surgical procedures?

❑ implants ❑ explants ❑ reduction ❑ biopsy ❑ marker placement ❑ lumpectomy ❑ mastectomy

Have you ever been diagnosed with breast cancer? ❑ Yes ❑ No If "YES," give year & treatments received?

_____

OBSTETRICAL / REPRODUCTIVE HISTORY

How many pregnancies have you had? _____

Resulting in (#): ____ Full 9 months ____ Premature ____ Miscarriage / Abortion ____ Living children

What were your ages at the time of deliveries?

Were there any complications during pregnancy, labor, delivery, or post partum?

❑ Vaginal laceration ❑ Episiotomy ___ degree ❑ C-Section ❑ Vacuum ❑ Forceps

❑ Post-partum hemorrhaging ❑ Medication for bleeding ❑ Other _____

Are you currently sexually active? ❑ Yes ❑ No

Birth control method: ❑ Nothing ❑ Pill ❑ Vasectomy ❑ Vaginal ring ❑ Depo provera

❑ Condom ❑ IUD ❑ Hysterectomy ❑ Diaphragm ❑ Tubal Sterilization

❑ Other _____

OBSTETRICAL / REPRODUCTIVE HISTORY (continued)

Are you able to orgasm with sex? ❑ Yes ❑ No

Do you experience difficulty having an orgasm? ❑ Yes ❑ No If "YES," does it bother you? ❑ Yes ❑ No

If you are or have been sexually active, which of the following sensations have you experienced with sexual intercourse?

- ❑ Deep pain with intercourse
- ❑ Pelvic pain after intercourse
- ❑ Burning vaginal pain after intercourse

If you have pain with intercourse, does it make you avoid sexual intercourse? ❑ Yes ❑ No

Have you had yeast infections? ❑ Yes ❑ No How frequently? _____

Have you had sexually transmitted infections? ❑ Yes ❑ No If "YES," please check which one(s).

❑ Herpes ❑ Venereal Warts ❑ HPV ❑ Gonorrhea ❑ Chlamydia ❑ Trichomoniasis ❑ HIV ❑ Hepatitis

Do you experience the following:

❑ pain in lower abdomen ❑ pain in lower back ❑ pain in vagina ❑ pain in vulva

URINARY SYMPTOMS

How many times do you typically go to the bathroom **during the DAY** (to empty your bladder)? _____

How many times do you typically go to the bathroom **during the NIGHT** (to empty your bladder)? _____

Which of the following do you experience?

- ❑ Pain associated with your bladder?
  - ❑ Pain when bladder is full
  - ❑ Pain with urination
  - ❑ After voiding
  - ❑ Other _____
- ❑ Urgency ❑ Frequency
- ❑ Loss of urine when coughing, sneezing, laughing, or lifting heavy objects?
- ❑ Difficulty passing urine? ❑ Difficulty emptying bladder?
- ❑ Still feeling full after urination? ❑ Feeling the need to void again shortly after urination?
- ❑ Frequent bladder infections? ❑ Blood in the urine?

RECTAL SYMPTOMS

Check the following that you experience in your rectum

❑ pain ❑ pain with bowel movements ❑ itching ❑ burning

❑ hemorrhoids ❑ bleeding or blood in your stool

❑ increased abdominal pain with bowel movements

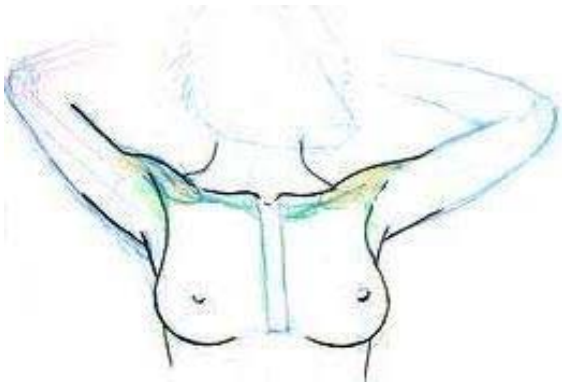
❑ abdominal pain decreases after completing bowel movement

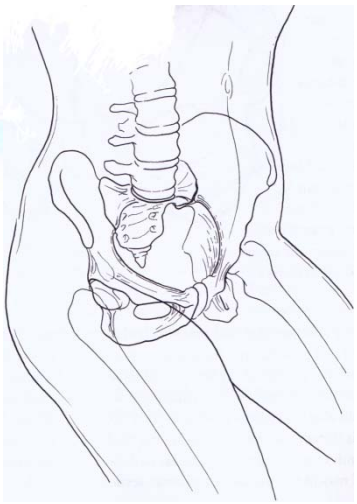
The words below are commonly used to describe pain and other sensations.

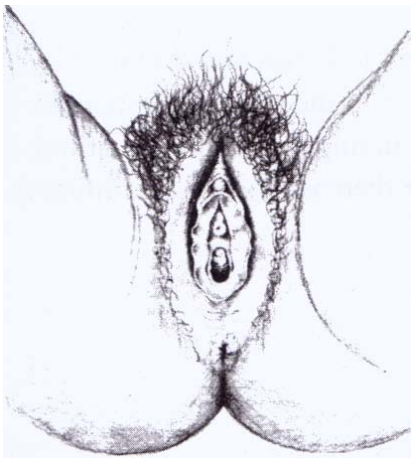
1) Place a check mark (√) in the column which represents the degree to which you experience that type of feeling. Please limit yourself to a description of the pain or sensations in your **pelvic & breast areas <u>only</u>**.

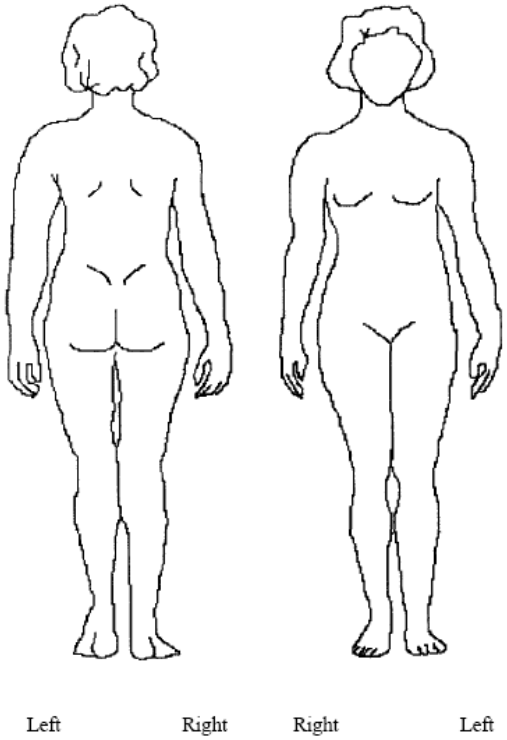
2) On the pictures below, put the number of the sensation at the location you feel it (if you are able to identify a location).

Type	***None***	***Mild***	***Moderate***	***Severe***
1 Throbbing				
2 Shooting				
3 Sharp				
4 Cramping				
5 Aching				
6 Gnawing				
7 Hot-Burning				
8 Rippy				
9 Itchy				
10 Buzzy				
11 Pinching				
12 Heavy				
13 Tender				
14 Splitting				
15 Tiring-Exhausting				
16 Sickening				
17 Fearful				
18 Punishing-Cruel				









Please mark on the drawing other areas that you experience pain.

Please describe activities (not mentioned above) during which you experience pain.

_____

_____

_____

_____

_____

_____

_____

COPING MECHANISMS & PAIN MANAGEMENT

Who are the people you talk to concerning your pain, or during stressful times?

❑ Spouse / Partner ❑ Relative ❑ Support group ❑ Clergy
❑ Doctor / Nurse ❑ Friend ❑ Mental Health provider ❑ I take care of myself

How does your partner deal with your pain? ❑ Not applicable

❑ Doesn't notice when I'm in pain ❑ Takes care of me
❑ Withdraws ❑ Feels helpless
❑ Distracts me with activities ❑ Gets angry

What helps your pain?

❑ Lying down ❑ Relaxation ❑ Meditation ❑ Music
❑ Massage ❑ Ice ❑ Heating pad ❑ Hot bath
❑ Pain medication ❑ Laxatives / Enema ❑ Injection ❑ TENS unit
❑ Bowel movement ❑ Emptying bladder ❑ Nothing ❑ Other _____

What makes your pain worse?

❑ Intercourse ❑ Orgasm ❑ Stress ❑ Full meal
❑ Bowel movement ❑ Full bladder ❑ Urination ❑ Standing
❑ Walking ❑ Exercise ❑ Time of day ❑ Weather
❑ Contact with clothing ❑ Coughing / sneezing ❑ Not related to anything
❑ Other _____

Of all the problems or stresses or your life, how does your pain compare in importance?

❑ The most important problem ❑ Just one of many problems

SEXUAL AND PHYSICAL ABUSE HISTORY

Please answer the following questions if you believe they are relevant to your concerns, issues, or pain.

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted ❑ Yes ❑ No ❑ No answer

1. Check an answer for both as a child and as an adult.	As a child (13 and younger)	As an adult (14 and over)
a. Has anyone ever exposed the sex organs of their body to you when you didn't want it?	❑ Yes ❑ No	❑ Yes ❑ No
b. Has anyone ever threatened to have sex with you when you did not want it?	❑ Yes ❑ No	❑ Yes ❑ No
c. Has anyone ever touched the sex organs of your body when you did not want this?	❑ Yes ❑ No	❑ Yes ❑ No
d. Has anyone ever made you touch the sex organs of their body when you did not want this?	❑ Yes ❑ No	❑ Yes ❑ No
e. Has anyone forced you to have sex when you did not want this?	❑ Yes ❑ No	❑ Yes ❑ No
f. Have you had any other unwanted sexual experiences not mentioned above?	❑ Yes ❑ No	❑ Yes ❑ No

If yes, please specify _____

2. When you were a child (13 or younger), did an older person do the following?

a. Hit, kick, or beat you?	❑ Never	❑ Seldom	❑ Occasionally	❑ Often
b. Seriously threaten your life?	❑ Never	❑ Seldom	❑ Occasionally	❑ Often

3. Now that you are an adult (14 or older), has any other adult done the following?

a. Hit, kick, or beat you?	❑ Never	❑ Seldom	❑ Occasionally	❑ Often
b. Seriously threaten your life?	❑ Never	❑ Seldom	❑ Occasionally	❑ Often

Leserman, J, Drossman D, Li Z. The reliability and validity of a sexual and physical abuse history questionnaire in female patients with gastrointestinal disorders. Behavioral Medicine 1995;21:141-148.

In the space below, please list and date chronologically any life changes in occupation, relationships, residence, physical or mental health in the past 10 years (e.g. moves, change in financial status, marriage, divorce, family additions, death of family member/close friend, time caretaking, illness diagnosis, etc.). Use the back of the page if more room is required.

Informed Consent for
Women 2 Women Restorative Therapy Sessions

(Please read before signing!)

I understand that the services I receive from Women 2 Women Restorative Therapy (W2WRT) are for the relief of physical pain, utilizing gentle hands-on techniques directly on skin. While I expect benefits from the treatment, I understand and accept that such benefits and desired outcomes cannot be guaranteed. I understand that my own motivation and regular attendance and participation at scheduled sessions and self-treatment will produce the optimal possible benefit from therapy. I understand that occasionally, referrals are made to other health professionals if deemed appropriate. Additionally, I understand that I am free to discontinue treatment at any time.

I understand that W2WRT sessions do not constitute medical care and that if I have health concerns it is my responsibility to seek professional medical advice. Practitioners of W2WRT are not qualified to diagnose disease or illness, and nothing said during the course of the session should be construed as such. I agree to inform the W2WRT practitioners of any known medical conditions or changes in my health so that practitioners can perform the safest treatment possible.

I understand the practitioner is not providing emergency services and if I have an emergency I should call 911 and/or immediately go to the nearest hospital emergency room.

I understand the relationship between the practitioner and client is a professional one. Requests for friendship between practitioners and clients are not considered beneficial. For the safety and best treatment outcomes for the client, practitioners at W2WRT will not establish friendships with clients. This precaution is for the benefit of the client and ensures that the practitioner maintains the ability to remain in a professional role for the client. Additionally, it is understood that any sexually suggestive remarks or advances made will result in the immediate termination of the session and termination of the professional relationship.

I understand that my participation in W2WRT sessions will remain confidential. Voice mailboxes are confidential. The nature of email is such that if I wish to communicate confidentially, I will not use email but rather use voicemail. If I do choose to communicate via email, I understand and accept that confidentiality cannot be guaranteed by the practitioners. In addition, if I happen to see W2WRT practitioners in public, I understand that the practitioner will not approach me and will only speak with me if I initiate the conversation.

While the work is gentle and will never cause injury, I understand that if at any time I am uncomfortable with or have concerns about the treatment that I am receiving, I will immediately inform the practitioner and treatment will be modified or halted.

I have had the opportunity to discuss all the aspects of Women 2 Women Restorative Therapy sessions fully, have had my questions answered, and understand the treatment planned. I am not aware of any reason why I should not proceed with Women 2 Women Restorative Therapy sessions, and I agree to participate fully and voluntarily.

Client's Printed Name: _____

Client's Signature: _____ Date: _____