Dayton family Massage

Fertility Massage Confidential Health Form

Name: _____

Birthdate: _____

Phone (cell): _____(work):_____

Address: _____

_____

Email: _____

Date of first massage appointment:_____

No. of pregnancies:_____ Any Miscarriages:_____

Number of births:_____

Are you seeing a fertility specialist? ® Yes ® No

Who?_____

Have you ever experienced a therapeutic massage before? ® Yes ® No

How long have you been actively trying to conceive?_____

Are you currently taking any medications including herbal? ® Yes ® No

If YES, what are they?_____

Do you currently have any areas of discomfort? ® Yes ® No

If YES, what are they?_____

Do you have any past injuries or surgeries that I should know about? ® Yes ® No

What is your current occupation?_____

Are you seeking out and are open to other alternative therapies? This would include herbal medicine, acupuncture and chiropractic?_____

Is your partner open to receiving therapeutic massage? _____

Would you both be interested in an instructional session to give you tools for working on each other?

® Yes ® No

NOTES: _____

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**Disclaimer: We do not treat or prescribe within the context of our massage therapy session.*

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Date of Last Menstruation: _____

If actively trying to conceive, appointments need to be between menses and ovulation.

No massage upon ovulation until menstruation.

Are your cycles regular? ⑧ Yes ⑧ No

Do you know when you ovulate? ⑧ Yes ⑧ No

How is your diet and partner's diet? Have you consulted a nutritionist or herbalist, acupuncturist about your diet?_____

_____

_____

_____

_____

What do you think is inhibiting conception?

⑧ Hormones ⑧ Congestion ⑧ Timing ⑧ Age ⑧ Diet ⑧ Lifestyle

_____

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NOTES: _____

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