Pelvic Wellness & Fertility ▪ Pre and Peri Natal, Postpartum & Infant Massage ▪ Therapeutic Medical Massage
Donna J Zubrod, MSc, LMBT NC license #7120, CD(DONA)

Confidential Client Information and Consent for Fertility Massage - Female

Welcome and thank you for allowing me to work with you. The information you provide below will help me offer you the best service possible. Your information will not be shared with others, including your partner, unless I inform you and you also give me your written consent. At times, I may recommend that you share certain information with your partner and healthcare providers.

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
City/State: _____ Zip: _____ Cell Phone: _____
Email address: _____ Circle YES or NO to receive my educational newsletter
Date of Birth: ____/____/____ Age: _____ Height: _____ Weight: _____
What is your fertility partner's name? _____

How did you learn about me and the fertility services that I provide?? *(e.g. google search, friend, healthcare provider)*
_____

What is your occupation? _____ What is your industry/employer?_____
Describe your work life *(e.g. # hours/week; # hours at computer, stressors coming from work)*: _____
_____

Please list current medications/herbal supplements used and for what purpose *(during the time you are trying to conceive, I recommend that you work with a certified herbalist and family physician when taking herbal supplements. Discuss all medications with your fertility specialist/ob-gyn or family physician*). You may also want to list meds/herbs taken in past 2-3 years.
_____
_____

Who is your fertility specialist? _____Phone: _____
Who is your Ob/Gyn: _____Phone: _____

Please list all other health care providers on your fertility wellness team *(e.g. acupuncturist, herbalist, chiropractor, etc)*

Is your partner open to participating in your fertility massage experience? I cater to each partner's needs and strongly recommend that your partner be involved _____If not, have you and your partner discussed other ways for him/her to be supportive of this journey? _____

Please share with us some things about your life surrounding your previous/current fertility experiences:
Number of pregnancies: _____ Any miscarriage(s)? _____Have you ever had C-section? _____
Other information about birth: _____

How long have you been actively trying to conceive? _____
_____

How do you feel about the experience so far? _____
_____

What do you think your partner is feeling? _____
_____

Have your doctors suggested any reasons for difficult conception? If yes, were the reasons definitive or a probability? *(Include any tests performed and results)*
_____
_____

By appointment in Cary at 120 Dry Ave 919.810.0003 donna@sevengenerationswellness.com

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Confidential Client Information and Consent for Fertility Massage - Female

Why do you think you might be having difficulty conceiving *(please answer for yourself and not based on what your doctor or partner has suggested/stated)*? _____ Hormones _____ Timing _____Age _____Diet _____Lifestyle_____ Other
Please describe: _____

What is the date of your last menstruation? _____ (*If you are actively trying to conceive, appointments need to be between day 5 of your cycle and 2 days prior to ovulation and no massage upon ovulation until menstruation.)*
Have your cycles always been regular, irregular, or mixed? _____ Are they regular now? _____
Do you know when you ovulate? _____ *(if you are unsure, ask your therapist to explain this question)*

Describe your diet and lifestyle: *(I recommend you work with a nutritionist/acupuncturist/chinese medicine practitioner and/or your Ob/gyn if you are actively trying to adjust your diet to fit fertility needs).*

Caffeine intake (cup(s) per day)_____ fruits/veggies (# per day) _____
Comfort foods: (Candy, fried foods, other and # per day_____
Water intake (Oz per day) _____ Alcohol and smoking (# per day)_____
Exercise (type and frequency)_____

Have you ever received therapeutic massage? _____ How would you describe your experience?_____

Do you currently have any aches and pains or areas of discomfort? Are they chronic or just passing through? _____

Describe and date ALL past surgeries, car accidents, head trauma. Also include any abdominal and pelvic surgeries.
_____

Your massage therapist will be catering the session to your conception goals rather than treating for pain relief measures. Abdominal, buttocks, and pelvic regions are indicated for treatment in the fertility massage and your modesty and comfort needs will be met.

My Informed Consent. ***I understand and agree that: (please initial).***

_____ The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me by my massage therapist.
_____ My massage therapist does not diagnose illness, disease, or any other medical, physical or mental disorder, nor perform spinal manipulations.
_____ Massage therapy is not a substitute for medical treatment, and I am responsible for consulting a qualified physician for any physical ailments that I may have.
_____ It is necessary that my massage therapist be aware of any existing physical conditions that I have. I have listed all my known medical conditions, medications and physical limitations. I will update my massage therapist on any changes.
_____My therapist reserves the right to decline, discontinue, or restrict services based on any information I have provided in this form or during a follow-on session intake interview that may indicate that massage therapy would put my health or my therapist's health at risk.
_____ Any and all information collected during massage therapy sessions remains confidential and shall not be released without my written consent.
_____ It is only fair to me and to my therapist that I speak up at any time during my session if I have concerns or questions.
_____ All therapeutic massage is non-sexual. I understand that sexual activity is prohibited within the therapist-client relationship regardless of who initiates such activity. Should the therapist or client make advances or have sexual intentions relating to the massage, both parties have the right and the responsibility to terminate the session.
_____All services rendered to me are charged directly to me and I am responsible for payment unless prior arrangements have been made. If I need to cancel or reschedule my appointment I will give my therapist 24 hour notice. I agree to pay the full value of the session price should I cancel without notice. I understand that cancellations within an hour of the session may be subject to partial payment.
The information provided on this confidential intake form is correct to the best of my ability. I will uphold all policies.

Signature _____ Date _____

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