Peaceful Pause Massge and Wellness LLC
Postpartum Intake Form

Client Name:_____ Date:_____

Address:_____

Phone:_____ Home Work Cell (circle one)

DOB:_____ Gender:_____ Preferred Pronoun:_____

Email:_____ Referred By:_____

Emergency Contact:_____ Phone:_____

General Medial History

Are you currently under the care of another healthcare provider? Yes No (Circle one)

If yes, for what reason:_____

Current Medications and/or Supplements:_____

_____

Allergies? Specify allergen & reaction:_____

Surgical History (year and type) and/or Recent Procedures:_____

_____

Accidents or Hospitalizations? _____

History of Trauma and/or Recent Traumatic Experiences? Yes No (Circle one)

If yes, briefly explain if comfortable:_____

Please review and circle the following conditions you currently have or have recently experienced:

Headaches Sinus Conditions Nerve Pain Cancer Painful/Swollen Joints

Asthma Bruise Easily Skin Disorders High/Low Blood Pressure Autoimmune Issue

Cold Hands/Feet Digestive Disorders Sleep Disturbance Fainting Spells

Anxiety Depression Seizures Varicose Veins Hemorrhoids Heart Condition

Menstrual History

Please review and check any of the following that apply to you, past or present:

	Past	Present		Past	Present
Painful Periods			Irregular Cycles		
Heaviness in Pelvis			Dark Blood at start/end		
Excessive Bleeding			Headache/Migraine		
Dizziness			Painful Ovulation		
Bloating			Failure to Ovulate		
Endometriosis (if known)			Fibroids (if known)		
Uterine or Cervical Polyps			Cysts Location:		
Vaginal Infections			Uterine Infection		
Bladder Infections			Urinary Incontinence		
Painful Intercourse			Fecal Incontinence		
Episodes of Amenorrhea			Vaginal Dryness		

Other (not listed):_____

Pregnancy and Postpartum History

Number of Pregnancies:_____ Miscarriages:_____ Terminations:_____

Number of Births:_____ Dates:_____

Complications during pregnancy?_____

Complications during birth?_____

Complications in Postpartum?_____

Briefly explain your most recent birth experience:_____

_____

Did you birth Vaginally or Cesarean? Please circle one

If Vaginally, did you tear or have an episiotomy? Yes No What degree of Tear?_____

Did you experience any postpartum hemorrhaging? Yes No

Did you experience any prolapse after birth? Yes No

If yes, what kind of prolapse? Uterine Rectal Bladder (circle one)

Are you currently Breastfeeding? Yes No

If yes, any concerns with supply, flow, latching, etc? Explain:_____

_____

Please circle any of the following changes in mood you are currently experiencing:

Anxiety Depression Rage Psychosis Grief Overwhelm Depletion

What kind of support system do you have currently? _____

Does this feel like enough? Yes No

Please share any other information that you feel is important to know regarding our work together:

_____

_____

_____

Consent to Treatment

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations (unless specified under his/her professional scope of practice). The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the practitioner updated on my health and understand that there shall be no liability on the practitioners part if I fail to do so. Understanding all of this, I give my consent to receive care.

Client Signature:_____ Date:_____