Chaya Leia Aronson, RN, BSN
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Patient Intake Form & Health History

Date of initial visit:	
Name:	
Address:	
Cell phone:	Date of birth:
Home phone:	Age:
Email address:	Occupation:
Marital status:	Referred by:

Patient Consent

Payment information: Payment is due at time of service or before. Receipts on request. Unfortunately, Chaya is unable to accept health insurance, but she can accept most Health Savings Accounts (HSAs).

Cancellation and no-show policies: If you must cancel or reschedule, please do so at least 48 hours in advance. **We charge for the full session for cancellations made with less than 48 hours' notice.** In inclement weather, Chaya will contact you that day. Chaya is quite forgiving when a woman must reschedule due to menstruation, but requires that you reschedule, or you will be charged for the full session. Thank you for understanding.

Pelvic Floor Evaluation/Treatment: If you are receiving a pelvic floor assessment and treatment, this can include an internal vaginal exam to assess pelvic musculature health. Treatment of any findings may include internal vaginal massage, instruction in pelvic muscle and breathing exercises, rectal assessment, massage, and the Arvigo Techniques of Maya Abdominal Therapy. If you prefer to receive only abdominal massage without internal pelvic work, please specify prior to treatment. At the beginning of each initial session with a client, Chaya performs a thorough intake during which this will be addressed.

Privacy Practices: Health Insurance Portability & Accountability Act (HIPAA) regulations require all practitioners to have a signed release form from their client *before* taking any notes about them. This health history and any additional notes for the purpose of your client care and Chaya's research and understanding of pelvic floor health and healing.

I, _____, give my permission to Chaya Leia Aronson, RN, BSN, to take my health history and notes in our sessions, and to use this data for my care as well as research purposes. I understand that my identifying information, such as name, birthday, and address, will not be included.

I understand the payment and cancellation policy. I understand that a copy of this form is available upon request.

Signature: _____ Date: _____

Health History

What is the primary reason for your visit today?
When did it start?
What brought it on?
Describe any stressors that were occurring at the time:
Do any activities provide relief?
Do any activities make it worse?
Are you working with any other practitioners? If so please list their name(s) and modalities:
What medications, herbs, and/or supplements are you currently taking?
Do you have any allergies?
What surgeries have you had, if any, and when?
Have you ever been hospitalized? When and for what?
What accidents have you had, if any (car crashes, falls on ice, injuries to sacrum, head, or tailbone)?
Do you have any other relevant health history to share?
Do you have any relevant family health history to share?

Digestion

Describe your typical daily diet (breakfast, lunch, dinner, and snacks):
How much water do you drink each day?
How much caffeine do you have each day?
Do you have any food cravings? What foods?
Do you binge eat? What foods?
Do you have gas or bloating after eating? What foods trigger this?
List any food allergies or intolerances:
How frequently do you have a bowel movement?
Do your stools sink or float?
Do you experience constipation? Diarrhea? Mucus in stool? Blood in stool? Pain with stooling?

Urination

Do you urinate frequently?
Do you have pain or burning with urination?
Do you get up at night to urinate? How often?
Have you ever had…? (check any that apply) ☐Urinary tract infection (UTI) or bladder infection ☐Recurrent UTIs ☐Interstitial cystitis ☐Urinary incontinence

Pelvic Health

Menstruation

What was the date of your last Pap smear?	What were the results?
What was the date of your last menstrual period?	How long did it last?
How does your menstrual cycle feel?	
How old were you when you first got your period? What was this like for you?	
What menstrual products do you use?	
What contraceptive methods do you use?	
Are you pregnant now?	
Are you currently trying to conceive?	
Have you had fertility challenges (now or in the past)?	

Menstrual Symptoms

With your period, do you have or have you had any of the following symptoms? (check all that apply)

- ☐Ovulation pain
- ☐Premenstrual anxiety
- ☐Premenstrual depression
- ☐Premenstrual insomnia
- ☐Premenstrual heaviness in pelvis
- ☐Menstrual pain
- ☐Headache or migraine with menses
- ☐Dizziness
- ☐Bloating or water retention
- ☐Painful intercourse
- ☐Dark blood at beginning of cycle
- ☐Dark blood at end of cycle
- ☐Excessive bleeding
- ☐Light bleeding
- ☐Amenorrhea (missing menstrual cycle). How long?

Other Pelvic Symptoms

Do you have or have you had any of the following? (check all that apply)

- ☐Fibroids
- ☐Endometriosis
- ☐Vaginal dryness
- ☐Polycystic ovaries
- ☐Ovarian cysts
- ☐Sexually transmitted infection (STI); if yes, which one(s)?

Sexual History/Experience

How would you rate your interest in sex (high, moderate, low, none):
Do you have difficulty experiencing orgasms?
Do you have pain with sex? If so, in which position(s)?
Have you had a bladder infection or UTI that you attribute to a sexual experience?
Have you experienced sexual, physical, or emotional trauma? If yes and you wish to share more about this, please do:
If yes, did you undergo counseling for this experience? Was it helpful?

Pregnancy and Postpartum

How many pregnancies have you had?	Dates:
How many miscarriages have you had?	Dates:
How many terminations have you had?	Dates:
How many times have you given birth?	Dates:
Please describe any complications or challenges of any of the above:	
Describe your experience of pregnancy:	
Describe your experience of labor:	
Describe your experience of birth:	
Describe your experience of the postpartum period:	

Maternal Family History

Did your mother struggle with infertility? If yes, please describe what you know about it:
What do you know about your personal birth experience, including any trauma?
What if any medications did your mother take during her pregnancy with you, if known?

Menopause Symptoms

At what age did your symptoms begin?
Describe your symptom rhythm and progression:
List any hormone replacement medications you are taking or have taken:
What age was your mother when she started menopause (if known)?
Do you have or have you had any of the following symptoms? (check all that apply) ☐Hot flashes ☐Depression ☐Insomnia/disturbed sleep pattern ☐Anxiety ☐Fatigue ☐Irritability ☐Memory loss ☐Spotting ☐Mood swings ☐Heavy cycles ☐Vaginal dryness ☐Irregular cycles

Other Medical History

Do you have or have you had any of the following? (check all that apply) ☐Asthma ☐Painful or swollen joints ☐Anxiety ☐Muscular tension, if yes, where? ☐Depression ☐Sciatica ☐Insomnia ☐Herniated discs ☐Frequent colds/sinus infections ☐Hernia, if yes, what kind? ☐Cold hands or feet ☐Skin issues, if yes, what type? ☐Swollen ankles ☐Cancer, if yes, what kind? ☐Sore heels while walking Past or present?

Lifestyle, Emotional and Spiritual

What is your opinion of yourself?
Describe your most positive emotion: When do you typically experience that?
Describe your most negative emotion. When do you typically experience that?
Do you have a spiritual/religious practice? Describe:
List your hobbies and passions:
Describe your exercise routine:
Describe your intentions/visions for your next: 6 months: 1 year:
Do you use: ☐Tobacco? How much? ☐Alcohol? How much? ☐Marijuana? How much?
Do you think you have an addiction to any of these substances?