Re-Member Massage, LLC
1675 SW Marlow Ave, # 307D, Portland, OR 97225; PH: 503-939-9123
Nanci Williams, LMT #14787
All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Holistic Pelvic Care™ Intake Form

Patient Information:

Name_____________________________Date of Birth___________ Date___________

Occupation____

Source of Referral_________________________Phone/Fax of Dr./ND/DC__________
Home address____

E-Mail____

Home/Cell phone_____________________________ Work phone_________________

History:

1. What concern, symptom, problem or exploration brings you here?

2. When and how did this begin?

3. What treatments and/or tests have you received for this concern?

4. What are your goals for treatment?

5. Please list any pertinent medical diagnoses/treatments related to the above:

Past Medical History

Name:____
Date:___________________________

1. Date of last pelvic exam/PAP:_____________Results:_______________________

2. Any history of abnormal PAP?__________ Date of abnormal PAP:_____________

3. OB History: # of preg________
Date/Type (vag/cesarean) of deliveries______________________________________
# of miscarriages _______ Date/Description of ea. Delivery and/or miscarriage______
____
____

4. Please list types of birth control/length of time utilized________________________

5. Please list and date any pelvic or abdominal surgeries_________________________

Please check and date, or write **P** for present, next to any of the following ailments you have had:

____low back pain_____________________ ____pelvic/abdominal pain________________

____menstrual pain/PMS________________ ____prolonged bleeding/altered cycles________

____pain during sex____________________ ____sexually transmitted disease____________

____fibroids/cysts_____________________ ____UTI/bladder infections________________

____hemorrhoids______________________ ____constipation/irritable bowel____________

____tearing w/ birth____________________ ____childbirth complications______________

____sexual abuse______________________ ____physical/other abuse__________________

____depression________________________ ____cancer___________________________

____drug abuse________________________ ____smoking habit______________________

____eating disorder_____________________ ____ rectocele/cystocele ________________

____Prolapse _________________________ ____ Bladder/Urination issues _____________

6. Please describe other relevant information:

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Statement of Consent

Print Name:____

Release of Information
I authorize Nanci Williams, LMT 14787 to release my medical records and discuss health related issues to all health care providers, case managers, insurance representatives and lawyers that are involved in my case. ______ Please initial

Billing Information
To maintain lower rates, insurance is not billed directly. A statement will be provided that you may send to your insurance company for reimbursement as they allow. I do not fill out forms or in anyway respond to requests from insurance companies, which may affect reimbursement.
Payment is due at the time of service. General Rates: $95 - $175 per visit. _______ Please initial

General Understanding
I understand that Massage Therapy and other related health care services from me are not in any way to be used instead of or in place of consulting a Physician for diagnosis and treatment of any physical symptoms; but to be used in conjunction with, or on the advice, referral, or prescription of a Physician. ______ Please initial

Cancellation Policy
I understand that my scheduled appointments are reserved exclusively for me. I agree to call my therapist as soon as I know I cannot keep an appointment. All missed appointments and cancellations made after 24 hours preceding any scheduled appointment, will be billed at full price. I agree to be responsible for these charges, and payment will be made before the time of my next visit. If I miss two appointments without notice, my treatment will be terminated and I will pay full price for my missed appointments. I understand that this policy is in place to assist my Massage Therapist in providing the best possible care to me and all others who benefit from her services. ______ Please initial

Pelvic Floor Evaluation and Treatment
If you are receiving a pelvic floor assessment, this includes an internal vaginal exam to assess pelvic musculature health. Subsequent and current treatment of findings may include internal vaginal massage, instruction in pelvic muscle and breathing exercises, rectal assessment and/or massage and other techniques as needed. I approve internal vaginal and/or rectal exam at the discretion of the therapist.
I understand there is no guarantee of outcome of any treatment. Clients may experience a range of effects as a result of treatment including many benefits; but also physical effects such as soreness and bleeding, as well as emotional responses to treatment. I understand and agree that if at any time I experience symptoms that concern me or difficulty integrating a pelvic session, I will promptly consult Nanci Williams and my primary care physician or counselor, as applicable. I also understand I have the option to accept or decline to provide a witness, in addition to myself and Nanci Williams, during my session. ______ Please initial

Acknowledgement of Privacy Practices and Release of Information
I understand that Nanci Williams, LMT #14787 can use and disclose health information about me, which may include written records or spoken words regarding health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, and similar types of health-related information, in the course of providing care to me. I have the right to receive a written Notice of Privacy Practices should I request it. I may also request that some of my health information not be disclosed, and understand that Nanci Williams is not required by law to agree to such requests.
By signing below, I have read, fully understand, and agree to the terms of this consent form, and request and consent to receive appropriate care from Nanci Williams, LMT. I understand the nature and the purpose of the session procedures, evaluation and course of treatment. I have been given the opportunity to ask questions, and my questions have been answered to my satisfaction.

Client signature_________________________________**Date**_____________________