NAME: _____ DATE: _____

Your information will be kept *completely confidential*.

Address:

Cell: Home: Work:

Email: Height: Weight:

D.O.B.: Age: Profession/past profession:

Do you have any medical conditions that would exclude you from physical activity in a session? Yes ___ No ___ Please explain:

Do you have any areas of your body that need special consideration?

Are you presently taking any medications or drugs? (Give name of medication, and for what condition):

Are you presently using any recreational drugs, alcohol or nicotine? (Give amount per day/week):

What psychological or bodywork training have you had?

What kinds of psychological or bodywork therapy have you experienced, and for what period of time?

Are you in therapy or having regular bodywork? If yes, with whom?

Does this person have pre and peri-natal facilitation skills? Yes ___ No ___

List other physicians or health care practitioners you are being treated by:

NAME: _____ DATE: _____

List any other support you have?

Please check what applies to your birth history:

___ an unmedicated vaginal birth in a hospital
___ an unmedicated vaginal birth at home
___ an anesthesia birth
___ cesarean section
___ a multiple birth
___ other birth complications, please explain:

___ with fetal heart monitor
___ with cranial suction
___ with forceps
___ breech

Please check what applies to your prenatal and birth history:

___ I had a twin that did not live. At what point in the pregnancy or postnatal time did your twin leave? _____
___ I was premature. How many weeks? _____
___ I was in Neonatal Intensive Care Unit – please state how long? _____
___ I was incubated. How long? _____
___ I was conceived through assisted reproductive technology (I.V.F., sperm or egg donor, etc) – please state which:

Where was your father during the birth?

Were you separated from your mother at birth? (sent to nursery)?

Were you breast-fed? ___ Yes ___ No If yes, how long? _____

Men, were you circumcised as an infant? Yes ___ No ___ If yes, was anesthesia used?

Please tell me about any interventions shortly after your birth such as hospitalization for illness or high jaundice, operations, illnesses as an infant or child.

Did either or both of your parents lose another child to miscarriage, abortion, stillbirth, or childhood death? If yes, are you aware of how this affected you? Give dates and circumstances:

NAME: _____ DATE: _____

Who raised you? Were your parents your natural parents? Where you raised by a single parent? If your parents split up, how old were you? Did you have other major primary care givers like grandparents, aunts, uncles, guardians or adoptive parents?

Do you or did you have siblings? Indicate ages relative to you, nature of relationship as children:

Please tell me any other information you know concerning **your conception**, your parents' attitude toward having you (planned, unplanned, wanted, confused, unwanted). If unwanted, did they consider or attempt abortion?

What do you know about **your life in the womb**, including physical effects (maternal or paternal smoking, drinking, drugs, mom's diet), and emotional effects including absence or presence of father during pregnancy or birth, parent's relationship with each other during your pregnancy, siblings' attitude toward your birth? If you are adopted, give information about transition in hospital and new family, as well as any birth history known:

Have you ever lost a child to miscarriage, abortion, stillbirth, death? Yes ____ No ____
If yes, please explain circumstances and dates and how this affects you today:

Have you ever been, or are you, in an abusive relationship? Yes ____ No ____
If yes, please state when, what relation the person was or is to you, whether the abuse was or is physical, sexual or emotional. If a past relationship, what action did you take? If present, what are you doing about it? Please give details:

NAME: _____ DATE: _____

Have you, or anyone in your family of origin, been diagnosed with mental health issues, e.g. bipolar, schizophrenia, depression, etc? Yes ___ No ___ If yes, please explain:

Have you or anyone in your family taken prescribed medications for mental health issues? Yes ___ No ___ If yes, please explain:

Have you ever been hospitalized for mental health reasons? Yes ____ No ____
If yes, please describe the circumstances and outcomes with dates:

Has anyone in your family ever attempted or committed suicide? Yes ____ No ____
Have you ever contemplated or attempted suicide? Yes ____ No ____
If yes, please describe the circumstances with dates:

Do you have children? Yes ____ No ____ If Yes, state their ages and your experience of their gestation and birth:

I agree to give 24 hours' notice to cancel or reschedule an appointment, and to pay the full fee for the session if the notice period is under 24 hours.

Signature _____ Date _____