Vaginal Steam Bath: Confidential Health History Form

Please **PRINT** and **ANSWER** **ALL** questions.

Date_____/_____/20_____

Full Name (First, Middle Initial, and Last) _____

Address _____City _____State _____ Zip _____

Cell Phone _____ (H) _____ (W) _____

Occupation _____Place of Employment_____

Height _____ Weight_____ DOB _____ Age _____ SSN# _____

Are you under the care of a physician? _____ If so, name? _____

How did you hear about us? **----------**

May we notify you of our specials by email: _____

***CONTRAINDICATIONS* Have you ever been diagnosed or experienced any of the following conditions? DATE all that apply.**

_____ Extremely Heavy Periods

_____ First Day of Last Cycle

_____ Open Wounds

_____ Sores

_____ Blisters

_____ Are You Pregnant?

_____ Currently Feverish

_____ IUD

_____ Herpes

Please Check ALL that apply:

_____ Infertility Issues

_____ Heavy Periods

_____ Recurring Bacterial Infections

_____ Severe Cramping

_____ Open Wounds/Sores

_____ Brown Blood during Period

_____ Black Blood during Period

_____ Are you Pregnant?

_____ Endometriosis

_____Currently Feverish

_____ Recurring Yeast Infections

_____ Abnormal Discharge

_____ First Day of Last Cycle

_____ Irregular Cycle

_____ Foul Odor

_____ Bladder Infections

_____ Blisters

_____ Purple Blood during Period

_____ Incontinence

_____ Birth Control

_____ Absence of Period

_____ Herpes

_____ Hysterectomy

_____ Prolapsed Uterus

_____ STI

_____ Live Births

_____ # of Still Births

_____ # of Sexual Partners

_____ Domestic Violence

_____ Hemorrhoids

_____ Fibroids

_____ Menopause

_____ STD

_____ Breastfeeding

_____ C-Sections

_____ # of Miscarriages

_____ Rape

_____ Sexually Active

_____ IUD

_____ PCOS

_____ PMS

_____ UTI

_____ # of Pregnancies

_____# of Ectopic Pregnancies

_____ # of Abortions

_____ Molestation

_____ Date of Last Sexual Activity

_____ Do you enjoy sex?

(ICE) In Case of Emergency Contact: _____ Phone: _____

I have not been diagnosed with any contraindications for vaginal steaming. I am aware that this facility does not have a Licensed Medical Director on site. I am aware adverse events such as vaginal spasms have been alleged and claimed with the use of vaginal steaming. Should I experience any irritation or abnormal sensations during the session, I will immediately stop my session. If during the session, I experience discomfort or pain, I am responsible for immediately stopping my session. I am aware that Trained Therapists do not diagnose, prescribe and do not cure or treat any condition or disease.

CLIENT SIGNATURE **X**_____ Date _____/_____/_____

(*For clients 18 or under, the signature & attendance of the parent/guardian for insertion is required)*

I have reviewed this form with my client. Therapist Signature **X**_____

ATTENTION: All prepaid discounted vaginal steaming sessions are to be used within three (3) months of purchase. No show appointments are counted as a used session without a 24 hour cancellation. Health History forms should be updated after twelve (12) sessions or every year. No refunds! Non-transferable!

CLIENT SIGNATURE **X** _____

(*For clients 18 or under, the signature & attendance of the parent/guardian for insertion is required.)*

First Session Evaluation: YES/NO

Did Therapist review Health History and inquire about any health issues? _____

Was the device, area, room, and restroom clean? _____

Were you covered and comfortable? _____

Were your results satisfactory? _____

Will you recommend us to family/friends? _____

Did you have any problems/discomfort during session? _____

If so, please explain:

_____

_____

How do you feel?

_____

CLIENT SIGNATURE X_____

Notes:_____

_____

_____

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