

Confidential Postpartum Intake Form

Harmonize, LLC

Contact Information

Name: _____

Home Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

DOB: ____ / ____ / ____ Whom may I thank for referring you? _____

Whom should I contact in an emergency? _____

Phone #: _____ Relationship to you: _____

Labor and Birth

When did you give birth? ____ / ____ / ____ Where? _____

Were there any complications? _____

How long was your labor? _____

How is/are your newborn's/newborns' health? _____

Overall Labor and Birth Experience: _____

Health and Lifestyle

Have you received bodywork in the past? Yes No If yes, what kinds and how often? _____

What are your children's names and ages? _____

Please list any medications, supplements or herbs you are currently taking: _____

How is your appetite? _____

How is your sleep? _____

Please Turn Over →

Please check any of the following conditions that you are currently experiencing:

- | | |
|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Low Back &/or Sacral Pain |
| <input type="checkbox"/> Breastfeeding Problems | <input type="checkbox"/> Neck/ Shoulder Tension |
| <input type="checkbox"/> Constant/ Acute Pain or Discomfort
Where? _____ | <input type="checkbox"/> Recovering from a Cesarean Birth |
| <input type="checkbox"/> Constant Worrying | <input type="checkbox"/> Emergency |
| <input type="checkbox"/> Constipation or Diarrhea | <input type="checkbox"/> Planned |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Recovering from Tearing/ Episiotomy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Redness, Heat or Swelling in Breasts |
| <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Skin Conditions or Infections |
| | <input type="checkbox"/> Other: _____ |

Do you have a history of:

- | | |
|--|--|
| <input type="checkbox"/> Allergies to Nut Oils | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Autoimmune Disease(s) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Physical, Emotional or Sexual Abuse |
| <input type="checkbox"/> Car Accident(s) | <input type="checkbox"/> Postpartum Depression &/or Anxiety |
| <input type="checkbox"/> Cesarean Birth (Previous Birth) | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Chemical Sensitivity | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Vertebral Disc Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other: _____ |

How are you feeling overall? _____

Could you use more help and support caring for your newborn? Yes No

Do you have any special needs or requests? _____

Consent to Treatment

To the best of my knowledge, this form is accurate and complete. I have disclosed all known health conditions and will inform Kristy of any changes in my health status at the beginning of future appointments. I consent to treatment.

Signature: _____ Date: _____

Harmonize Bodywork™ Informed Consent

I, _____, understand that massage therapy provided by Kristy Geffen is intended to enhance relaxation, reduce pain caused by muscle tension and adhesions, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes of our work together are specified below:

Physical and Energetic Therapeutic Support for Postpartum Healing

I understand that massage therapy is recommended as an adjunctive healthcare and that it is not diagnostic and it does not replace medical care from a primary care provider. The treatment procedure and possible contraindications have been explained to me.

I will pay for my session in full at the time of service via cash or check unless Kristy is billing my insurance company. If I am using insurance to cover the cost of treatment, I give my consent to Kristy Geffen to share my chart notes with my insurance company. I understand that if I cancel with less than 24-hours notice I will be charged for my session, except in the case of an emergency or illness. I will not receive treatment if I have a cold or flu. If I arrive late to my appointment, I understand that the appointment will still end at the scheduled time, and I will pay for my appointment in full.

I am aware that all information shared with Kristy during my bodywork session is completely confidential. Exceptions include:

- If I have given Kristy consent to share my chart notes with my insurance company
- If I share that myself or someone I know is currently being hurt, or is in danger of being hurt

I understand that I do not have to try bodywork techniques/procedures or receive bodywork in parts of my body that I feel hesitant, unsafe or unsure about. According to Oregon state law, Kristy will keep genitalia and breasts draped at all times unless I have requested therapeutic breast massage. I am aware that I can terminate a session or end our therapeutic relationship at any time, at my own discretion.

Signature

Date

Kristy Geffen, LMT, RPP
(503) 312-5878

5515 NE 30th Avenue
Portland, OR 97211