MAMA LOUNGE
2001 PINE STREET SAN FRANCISCO, CA 94115 (415) 857-3228 MAMALOUNGESF.COM

Pregnancy Intake

Name _____ Age_____ Date_____

Birth Date _____ /_____ /_____ Address: _____

City: _____ State: _____ Zip: _____ Phone(cell)_____

E-mail address: _____

How did you hear about Mama Lounge? Friend – (who?) _____

Internet _____ MD/Midwife/Doula _____ Other _____

Emergency Contact: _____ Relation: _____Phone #: _____

Regular Medical Doctor: _____

OBGYN or Midwife:_____ @ which Hospital or Home Birth?_____

Occupation: _____ Employer: _____

Please fill in what applies to you:

☐ I have tried the following natural/medical fertility treatments/procedures (fertility drugs, surgery, in vitro fertilization, etc)

_____
_____
_____

☐ I'm pregnant

☐ This is my first pregnancy - I'm carrying ☐ one ☐ two ☐ more: _____

I'm due: _____ I'm _____ weeks Starting maternity leave: _____

I'm planning on having a _____ month maternity leave

☐ I have birthed _____ babies in the past Children's ages: _____

Cesarean birth ☐_____

< 38 wks gestation ☐_____

Birth was induced ☐_____

Current and/or Past Pregnancies

Please indicate any pregnancy complications that you have experienced (miscarriage, ectopic pregnancy, premature labour, (pre)eclampsia, gestational diabetes, etc):

_____

_____

_____

Please indicate any PREGNANCY RELATED conditions you have experienced either in this CURRENT pregnancy (first box) or in any PAST pregnancies (second box):

C/P	C/P	C/P	C/P
☐ ☐ Muscle cramps	☐ ☐ Varicose veins	☐ ☐ Vulvar varicosities	☐ ☐ Other pain:
☐ ☐ Headaches	☐ ☐ Sinus concerns	☐ ☐ Hemorrhoids	_____
☐ ☐ Carpal tunnel pain	☐ ☐ Anxiety/depression	☐ ☐ Neck pain	_____
☐ ☐ Sciatica	☐ ☐ Fatigue	☐ ☐ Upper back pain	_____
☐ ☐ Constipation/Gas	☐ ☐ Nausea	☐ ☐ Mid back pain	☐ ☐ Cramping/bleeding
☐ ☐ Restricted breathing	☐ ☐ Stress	☐ ☐ Low back pain	☐ ☐ Breech
☐ ☐ Swelling (edema)	☐ ☐ High/low blood pressure	☐ ☐ Pelvic pain	

General Questions

Have you ever had acupuncture before?				Y	N	
Are you trying for a natural birth?				Y	N	
Do you have a pacemaker, heart arrhythmia, or other heart condition?				Y	N	
Have you ever had blood-clotting problems or problems with bleeding?				Y	N	
Are you on blood thinning medications?				Y	N	
Do you take aspirin regularly?				Y	N	
Have you ever been diagnosed with Hepatitis?	HIV?	AIDS?	TB?	Y	N	When? _____

Surgical History: Please list all surgeries and approximate age:

_____

_____

Hospitalizations and approximate date:

_____

Specific allergies and reaction:

_____

Major Accidents/Injuries (include head injuries, fractures, deep cuts, serious sprains, etc.) Indicate date or age:

_____

What were the conditions surrounding your birth:

_____

Family Medical History (any medical conditions that run in your family)

Diabetes Who_____

Cancer Who_____

High Blood Pressure Who_____

Heart Disease Who_____

Stroke Depression/Mental Illness Who_____

Alcoholism/Drugs Who_____

Other_____ Who_____

Medication History

List all **medications and supplements** you are currently taking:

RX: _____ Dosage:_____Dates Started:_____
RX: _____ Dosage:_____Dates Started:_____
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RX: _____ Dosage:_____Dates Started:_____
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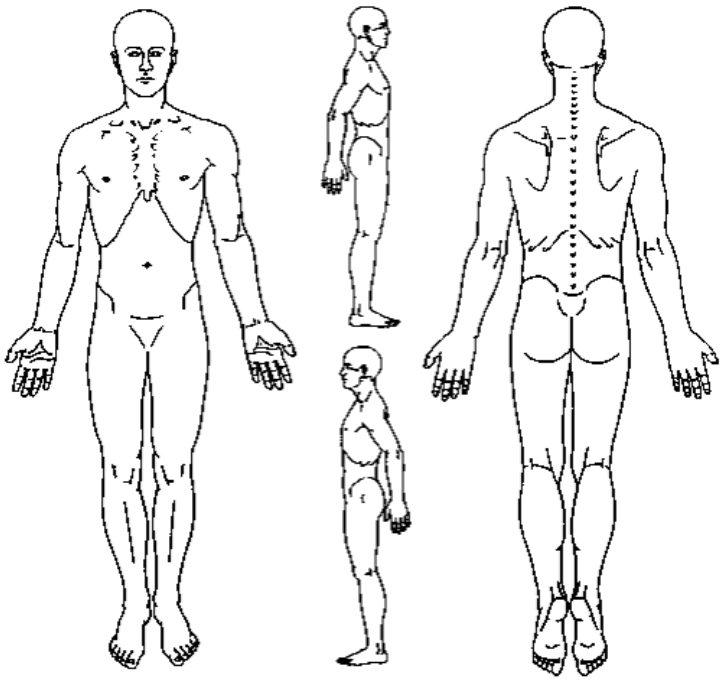
RX: _____ Dosage:_____Dates Started:_____
RX: _____ Dosage:_____Dates Started:_____

Pain

PAIN: please indicate on the figures below the areas of the body you experience pain:



How would you characterize your pain (mark all that apply):

☐ dull/achy ☐ sharp/stabbing ☐ burning ☐ tingling ☐ numbness ☐ electrical ☐ superficial ☐ deep ☐ shooting

The pain is (mark all that apply):

☐ better/worse with heat ☐ better/worse with cold ☐ better/worse with pressure ☐ better/worse with movement ☐ better/worse with rest ☐ worse in am/pm

Exercise, Diet & Energy:

On a scale of 1-10 please rate your energy level. _____

What time of day is your energy: Highest? _____ Lowest? _____

Do you fatigue easily? _____

Please list some of your favorite foods: _____

Mark all the foods/flavors you enjoy and eat often: ☐ spicy ☐ sweet ☐ salty ☐ bitter ☐ fresh/raw foods ☐ fried food ☐ dairy ☐ canned foods ☐ frozen foods/microwave meals ☐ fast food ☐ sodas ☐ coffee ☐ red meat ☐ white meat

How often do you exercise? _____

What kind of exercise do you do? _____

Emotions & Sleep:

Do you have (mark all that apply): ☐ panic/anxiety attacks ☐ bad/short temper ☐ nervousness ☐ sadness

☐ crying spells tendency to worry ☐ poor memory ☐ difficult concentration

Briefly describe a typical night of sleep for you. _____

How long do you normally sleep? _____ (hours per night) Do you take naps? _____ How often? _____

I have difficulties with (mark all that apply): ☐ falling asleep ☐ staying asleep ☐ dream-disturbed sleep

Do you often experience waking up and not being able to fall asleep again? ☐ No ☐ Yes, usually at_____ am/pm

Number of times per night you get up to use the restroom _____

On a scale of 1-10 please rate your stress level_____

How do you relax? _____

How do you feel about your work? _____

Are you in a relationship? _____ How do you feel about your relationship? _____

What is your most predominant emotion? _____

Patient Informed Consent to Care and Treatment

Acupuncture Consent to Treat

1. I, _____, hereby authorize the licensed acupuncturist at Mama Lounge to administer any style of Chinese Medicine relevant to my diagnosis and treatment, including but not limited to the following:

- Insertion of disposable, stainless steel acupuncture needles of various sizes into my body at different depths and locations.
- Heated moxibustion treatment using the herb Artemisia Vulgaris, or a heat lamp may be placed on or near any part of my body. There is also indirect moxibustion treatment where the herb may rest on the skin. The heat might cause slight discomfort or leave a small scar or blister on the skin. With any type of heat, there is risk of burn.!
- Vigorous massage called "gua sha" or regular massage that may produce redness, tenderness or slight bruising of the skin,
- Cupping may be used to promote circulation. Suction from the cups may produce red or purple bruising.
- Electrical Stimulation may be used to enhance the treatment at various acupuncture points.

2. I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases, dizziness or fainting. Although rare, there have been reports of nerve damage and organ puncture connected to acupuncture treatment. Infection is also a possible risk. However, I understand that this office uses only sterile disposable single-use needles, and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

3. The herbs and nutritional supplements used in Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I will notify the licensed acupuncturist at Mama Lounge if I am or become pregnant. I will notify the licensed acupuncturist at Mama Lounge immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements. I do not expect the licensed acupuncturist at Mama Lounge to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

4. I understand the licensed acupuncturist at Mama Lounge has the right to refuse treatment to any patient at any time. Reasons for refusal of treatment include crude behavior or inappropriate conduct

Massage Consent to Treat

1. I give my permission to receive massage therapy at Mama Lounge

2. I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.

3. I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.

4. I have clearance from my physician to receive massage therapy.

5. I understand the risks associated with massage therapy include, but are not limited to: superficial bruising, short-term muscle soreness, exacerbation of undiscovered injury; I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.

6. I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.

7. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so she may adjust accordingly.

8. I understand that I or the massage therapist may terminate the session at any time.

9. I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

Counseling Consent to Treat

1. Confidentiality
All information obtained in the course of the professional service is confidential unless there is a compelling professional reason for its disclosure. Your coach will disclose confidential information without a specific release if it is necessary to prevent foreseeable imminent harm to the client or another. In all circumstances, the coach will be judicious in the amount of information that is disclosed.
Coaches may disclose confidential information without the consent of the client only as mandated or permitted by law. When possible, coaches inform clients about the disclosure of confidential information and possible ramifications before the disclosure is made. Coaches will only disclose confidential information to third parties with the appropriate written consent.

2. Liability
This agreement is for Coaching, not Psychotherapy. Ms. Carol Jones is working only within the capacities of a Coach and will not be held liable for discrepancies. While coaching can work with issues such as identifying and reaching goals, and changing the behaviors that aren't working well for you, coaching will not address psychological issues such as depression and anxiety. For issues such as these, seek the medical attention from a Physician or Licensed Mental Health Professional in your area. By signing this agreement, you are agreeing that you understand the difference in these two functions and you will get appropriate professional help for mental health issues if necessary.

Authorization to Release or Obtain Information

I hereby authorize my provider at Mama Lounge to exchange all pertinent clinical information pertaining to me with other providers in the practice. I hereby release from liability and agree to indemnify and hold forever harmless all persons involved in this exchange of information from any loss, damage, claim or legal action arising out of such exchange of information. I understand these records may include personal and psychological information, and I may withdraw this authorization at any time, except to the extent
that action has been taken on this authorization.

By voluntarily signing below, I show that I have read (or have had read to me) and understand this consent to treatment. I have been told about the risks and benefits of acupuncture/massage/counseling and have had an opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature: _____

Name:_____Date:_____

THANK YOU FOR YOUR COOPERATION IN THOROUGHLY COMPLETING THIS FORM☺