Nurturing Traditions
Rachelle Garcia Seliga, CPM
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Postpartum Treatment—Client Intake Form

Contact Information:

Name_____Date of Birth:__/___/___ Today's Date:___/___/___

Primary Care Provider (Midwife or Doctor):_____

Source of Referral:_____

Home Address:_____

Home Phone:_____Cell Phone: _____

Email:_____

Birth History:

Date of most recent birth:_____

How many children do you have:_____

How many pregnancies have you had:_____

Have your births been vaginal or cesarean deliveries:_____

_____

How was your most recent birth experience for you/how do you feel about it?

_____

_____

_____

How was your previous birth experience/s for you—how how do you feel about them?

Subjective History:

What is the primary reason for your visit today/your major concern?_____

When and how did this begin?_____

Have you received any other treatments or tests for this concern?_____

What are your goals for treatment today?_____

Please list any other pertinent medical diagnoses/treatments:_____

Medical History:

Please list any pelvic or abdominal surgeries:_____

Please list types of birth control used/length of time utilized:_____

If you have now, or had in the past any of the following, please check and explain with dates:

_____Low back pain_____

_____Pelvic/Abdom Pain_____

_____Menstrual Pain/PMS_____

_____Prolonged Bleeding/Altered Cycles_____

_____Pain During Sex_____

_____Sexually Transmitted Disease_____

_____Fibroids/Cysts_____

_____UTI/Bladder Infections_____

_____Hemorrhoids _____

_____Constipation/Irritable Bowel_____

_____Tearing with Birth _____

_____Pregnancy/Childbirth Complications_____

_____Sexual Abuse_____

_____Physical/Other Abuse_____

_____Depression_____

_____Cancer_____

_____Drug Abuse_____

_____Smoking Habit _____

_____Eating Disorder _____

_____Other relevant info _____

Patient Consent:

Payment Information: Payment is due at the time of service. General Rates are $80-$160 per visit.

Cancellation and No Show Policies: I require a 24-hour cancellation notice for all appointments and expect fees to be paid in full if cancellations are made with shorter notice. If more then one appointment is cancelled, then I reserve the right to discontinue treatment.

Maya Abdominal Therapy Treatment: If you are receiving a Maya Abdominal Therapy Treatment, this treatment includes lower and upper abdominal work; gentle lymphatic treatment of the front legs; lower and upper back work; work on the sacrum, hips and coccyx; gentle hip corrections and the releasing of trigger points in the low back and buttocks. I understand and consent to these services, to be provided at the discretion of Rachelle Garcia Seliga, CPM. I also 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 or temporary exacerbation of pre-existing symptoms, as well as emotional responses to the treatment.

Holistic Pelvic Care TM Treatment: If you are receiving a Holistic Pelvic Care TM Treatment, this treatment includes internal vaginal work to assess pelvic musculature health, internal vaginal massage, instruction in pelvic muscle and breathing exercises and other techniques as needed. I understand and consent to these services, to be provided at the discretion of Rachelle Garcia Seliga, CPM. I also 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 or bleeding, as well as emotional responses to the treatment.

I _____, understand that Rachelle Garcia Seliga is a nationally Certified Professional Midwife (CPM) and has been attending births since 2002. I understand that it is through Rachelle Garcia Seliga's experience training and practicing midwifery at homebirths and birthcenters in Mexico and the United States, that she is offering me the treatment I am receiving today.

By signing below, I consent to evaluation and/or treatment of my condition by Rachelle Garcia Seliga, CPM. I understand the nature and purpose of the procedures, evaluation and course of treatment. I certify that I have read, fully understand and agree to the terms of this consent form.

Client signature:_____ Date:_____