INTEGRATIVE HOOD RIVER

STRUCTURAL INTEGRATION*EMBODIED PELVIC CARE*SOMATIC EXPERIENCING
413 Sherman Ave, Hood River, Oregon 541.490.4968
www.integrativehoodriver.com

Patient's Name: _____Date:_____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Work #: _____ Cell #: _____
Email_____ Referred by: _____
Date of Birth: __/__/____ Sex: M / F

Reason for today's visit:
_____
_____

Current medications: _____
Is a physician or any other medical personnel treating you presently? Y / N
If yes, please list name and number: _____
If yes, please list reasons for treatment and specific problem:
_____

Please check if you have (had) any of the following conditions:
__Arthritis __Bursitis __Broken bones __Cancer
__Diabetes __Fibromyalgia __Joint pain __High Blood Pressure
__Neurological problems __Pain (undiagnosed) __Skin condition
__Varicose veins __Headache __Sinus problems __Anxiety __Insomnia
__Depression __Numbness/tingling (where?) _____
__Breast Surgery __C-section
__ Surgery

If other, please explain:
_____
_____
_____
_____

Applicants for Structural Integration Series

I, _____hereby apply for a standard series of processing in Structural Integration (SI) and certify that the above information is true and accurate to the best of my knowledge. I fully understand the purpose of SI is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. This is done through direct manipulation and education so that greater freedom of body movement are achieved. I understand SI is not involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed. The Structural Integration Practitioner does not treat, prescribe or diagnose an illness, disease, or any other physical or mental disorder of the person. Nothing said or done by a SI Practitioner should be misconstrued to be such. I understand it is necessary for the SI Practitioner to touch my body in order to assist me in establishing balance and alignment in the body. I understand that I, the client, have the right to refuse any portion of any session at any time. I understand that I, the client had the right to discontinue the session at any time for any reason. I give the licensed practitioners of **Integrative Hood River LLC**, my permission and consent to do all those things necessary in helping me establish balance and alignment, including, but not limited to touching my body. I give the SI Practitioner full privilege and license to work on my body in such a way as to restore and establish balance and alignment therein. Furthermore, I understand that any relief of physical or emotional symptoms is coincidental in the organization of the total human being and is not the basic goal of Structural Integration.

_____(Client Signature)

_____/_____/_____ (Date)

EMBODIED PELVIC CARE

Current Medications: Please list all current medications (OTC, prescriptions, birth control, IUD etc.):

_____

_____

MENSTRUAL HISTORY (even if postmenopausal or no longer having periods)
When was your Last menstrual period?_____ Menopausal ____Y ____ N
Age at first period: _____ years
If your menstrual periods are regular; periods start every: _____ days
If your menstrual periods are irregular; periods start every: _____ to _____ days
Duration of bleeding: _____ days
Does bleeding or spotting occur between periods?□ Yes □ No
Does bleeding or spotting occur after intercourse? □ Yes □ No
Is pain associated with periods? □ Yes □ No
Birth Control?□ Yes □ No Type:_____

OB/GYN History
Pregnancy #_____Miscarriage _____Abortions _____ □ Yes □ No: Pelvic pain
Childbirth: Vaginal Deliveries # _____ □ Yes □ No: Painful vaginal penetration
Childbirth: C-Section #_____ □ Yes □ No: Vaginal dryness
Currently breastfeeding: □Yes □ No □ Yes □ No: Menopause – when?

Have you ever had any of the following conditions or diagnoses? Please circle all that apply.

Allergies	Fibromyalgia	Physical or Sexual Abuse	Headaches
IBS	Sexually transmitted disease		Heart problems
Stress fracture	Asthma	HIV/AIDS	TMJ/Neck
Autoimmune disease	Interstitial Cystitis	Arthritis	High Blood Pressure
Depression	Cancer	Hypo/Hyperthyroid	Diabetes

Describe any pain, discomfort or difficulty with intercourse or urination:

_____

_____

_____

INFORMED CONSENT FOR EMBODIED PELVIC CARE

I understand that I have the opportunity to give/revoke my consent at any time during each session.

_____

I understand that I may have a person of my choice accompany me during the session, and that the session will occur in clean, private & secure area.

_____

I understand that I will be required to fully or partially undress for the session and appropriate draping and coverings will be provided. Your practitioner will be fully clothed at all times.

_____

I will communicate relevant medical history information to the therapist including, but not limited to, medication use, IUDs (or other implants), pre-existing urogenital infection or known sexually communicable diseases.

_____

I understand that this session is performed by observing, palpating or inserting a gloved finger (sometimes two) into the perineal region including the vagina and/or rectum. This session will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region.

_____

Session treatment may include, but is not limited to the following: observation, palpation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

_____

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me. By signing below I acknowledge that I have read and understood the above information.

_____

Name: _____ DATE_____/_____/_____

Signed:_____

Shannon Northroup LMT/CSI/STREAM
OR LIC# 20673

Signed:_____

Stat. Auth.: ORS 687 Stats. Implemented: ORS 687.121

Internal Cavity

(1) An internal cavity massage must be performed using gloves and utilizing universal precautions for communicable disease control.

(2) Internal Cavities consist of nasal cavities, oral cavities, auricular cavities, anal cavities, and vaginal cavities.

(3) Prior to performing these special procedures, an LMT must:

(a) be able to present evidence of the completion of specialized contact hours as training beyond the minimum competencies, which includes but is not limited to, indications, contraindications, therapeutic treatment techniques, expected outcomes, client safety, client consent, client communication, draping techniques, sanitation, and ethical responsibilities related to internal cavity massage;

(b) be able to articulate a therapeutic rationale which is acknowledged by the client; rationale may include a medical prescription and/or permission to consult with the clients health care provider(s);

(c) acquire prior written and verbal consent before proceeding;

(d) intra-anal and intra-vaginal written consent must include clients' option to accept or decline to provide a witness, in addition to the client and LMT.

(4) While performing these procedures a LMT must use appropriate draping techniques at all times. Any temporary exposure of the genital area for the purposes of treatment is acceptable only in respect to appropriate procedures for that treatment. Immediately following treatment of the area, the genital area must be covered again.

(5) Under no circumstances will intravaginal or intra-anal techniques be performed on individuals under 18 years of age.

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