6700 Woodlands Parkway
Suite 230-151
The Woodlands, Texas 77382
(281)402-3268
Practice-Happiness.com

CLIENT INFORMATION

Date______________________________

~Personal Information

Last Name________________________ First Name _____________________________

Occupation _______________________Employer ______________________________

Date of Birth_________________ Home Phone Number __________________

Street Address________________________ Work/Cell Number__________________

City____State_______Zip______________

Status Single Married Divorced Widowed

Email__________________ Have you been here before? Yes No

☐ Please check if you DO NOT want to receive emails regarding special promotions or newsletters, or do not want email appointment reminders.

How did you hear about us?
☐ Friend/referral________________________
☐ Physician ____________________________
☐ Google Search________________________
☐ Saw advertisement in spa
☐ Other _______________________________

~Emergency Contact

Name______________________________ Relationship ________________________

Phone number ___________________ Alt. phone number __________________

CLIENT MEDICAL FORM

~Why have you presented to us?

____
____
____
____

~Medical History

Please list any health conditions you may have:

☐Diabetes Epilepsy Heart Disease High Blood Pressure Lupus

☐Skin Infection/inflammation Poor Wound Healing Irritable Bowel

Are you prone to Herpes outbreaks? Yes No Interstitial Cystitis

Other:_____________________________________ Cancer

____

Please list all medications and reason for taking them if not listed above:

____
____
____
____

Please list all surgeries:

____
____
____

Are you allergic to any medications? Yes No

If yes then explain medication and reaction:

____
____

Vitamin/Mineral Supplements taken? None _____________________________

____
____

~Life Style Information

What is your level of stress (1 being low, 10 high) :

☐1 2 3 4 5 6 7 8 9 10

Do you exercise? Yes No What activities?______________________________

Do you/did you smoke? Yes No

How many packs per day and for how long?

____

How many 8 oz. glasses of water do you drink per day? _________

How many caffeinated drinks do you drink per day? ________

How many drinks containing alcohol do you drink per day? ________

How much sun exposure do you receive? A lot Average Minimal

~Female Clients

Are you pregnant or lactating? yes no

Have you gone through menopause? yes no Currently Perimenopausal

Do you have undiagnosed abnormal vaginal bleeding? yes no
If yes then please explain____

____

Are you currently taking hormones? yes no

Are you up-to-date on your Pap smears/cervical/vaginal dysplasia screening?
yes no

Do you have a history of abnormal Pap Smears? yes no

____

____

Do you have a recent history of genital warts or STD's? yes no

____

Do you have a history of Pelvic Organ Prolapse? yes no

____

____

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Previous surgery for Pelvic Organ Prolapse or Urinary Incontinence? yes no
____
____

Are you currently sexually active? yes no.

If you are Sexually active, please also complete and print the FSFI form on the website.

Do you experience leakage of urine? yes no

If you are leaking urine, please also complete and print the Urinary Incontinence Form on the website.

How many vaginal deliveries have you had? 0 1 2 3 4 or more

How many Cesarean Sections? 0 1 2 3 4 or more

Have you had a 3rd or 4th Degree Laceration a during a vaginal delivery? (a tear in your rectal sphincter?) yes no

Have you had an epesiotomy a during a vaginal delivery? yes no

Patient Signature ____ **Date** ____________________

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