Serenity Wellness

Vaginal Steam Bath: Confidential Health History Form

CLIENT INFORMATION DATE:_____

Print Name:_____

Phone:_____ E-mail:_____

Address:_____

Age:_____ DOB:_____ Occupation:_____

Were you referred? YES ☐ NO ☐ If so, by whom?_____

Please check ALL that apply:	
Infertility Issues	
Recurring yeast infections	
Discharge	
Recurring bacterial infections	
Cramping	
Irregular period	
Brown blood during period	
Foul odor	
Black blood during period	
Bladder infections	
Purple blood during period	
PID	
Endometriosis	
Incontinence	
Absence of periods	
Hemorrhoids	

Contraindications (have you ever been diagnosed with or experienced any of the following conditions? Date all that apply.)		
Extremely heavy periods.	Date:_____	
First day of your last cycle.	Date:_____	
Open wounds.	Date:_____	
Sores.	Date:_____	
Blisters.	Date:_____	
Are you pregnant?	Due date:_____	

Emergency contact:_____ Phone:_____

"I have not been diagnosed with any contraindications for vaginal steaming. I am aware that this facility does not have a Licensed Medical Director on site. I am aware adverse events such as vaginal spasms have been alleged and claimed with the use of vaginal steaming. Should I experience any irritation or abnormal sensations during the session, I will immediately stop my session. If during the session, I experience discomfort or pain, I am responsible for immediately stopping my session. I am aware that Trained Therapists do not diagnose, prescribe and do not cure or treat any condition or disease."

Client Signature:_____ Date:_____