|  |
| --- |
| **Client’s File** |

|  |
| --- |
| **Personal information** |

|  |
| --- |
| **Full name:**  **Date of birth:**  **Phone number:**  **E-mail:**  **Marital status:**  **Height:**  **Weight:** |

|  |
| --- |
| **Answer the below questions:** |

1. **How is your menstrual period cycle?**

* Regular
* Irregular
* Absent

1. **How is your blood flow during your period?**

* Normal
* Low
* Very low
* Heavy
* Heavy flow and long period (*beyond days*)

*Additional comments about your flow* ……………………………………………………………………………………………………………………………………………..

1. **Have you been medically diagnosed with:**

* Endometriosis
* Adenomyosis
* Low ovarian reserve
* Tight cervix
* Tilted cervix
* Premature menopause
* PCOS *(Polycystic Ovary Syndrome)*
* Hashimoto
* Thyroid
* Diabetes
* High blood pressure
* None

***Other(s)*** ……………………………………………………………………………………………………………………………

1. **Are you currently under any medication?**

* Yes
* No

**If yes, which one(s)** …………………………………………………………………………………………………………….………………...

1. **Do you take any vitamin(s)/supplement(s)?**

* Yes
* No

**If yes, which one(s)** ……………………………………………………………………………………………………………..

1. **Have you ever been pregnant?**

* Yes
* No

If yes, was it:

* Natural pregnancy
* IVF (*please specify the number of IVF trials*) ..............................................................................

1. **Have you ever experienced miscarriage(s)?**

* Yes
* No

If yes, do you know on which day of your pregnancy the miscarriage happened?

...............................................................................................................................................

1. **Have you ever experienced abortion?**

* Yes
* No

1. **Do you use any lubricant(s) during your personal intercourse?**

* None
* Commercial water-based lubricants
* Natural oils (*coconut oil/olive oil*)
* Saliva
* Vaseline

1. **Do you smoke?**

* Yes
* No

1. **Do you drink alcohol?**

* Yes
* No