CONFIDENTIAL CLIENT INTAKE FORM

Name:____**Date of Initial Visit**______________________

Address____**State**_______________________**Zip**______________________

Home Phone_______________________**Work Phone**__________________**email**___________________________________

Date of Birth______________**Age**___________**Occupation**____

Marital status_________________**Referred by**____

Have you had massage/bodywork before?____________ **What type?**____

REASON FOR VISIT

What is your primary concern?____

What are other areas of concern?____

When did your first notice it?__________________________**What brought it on?**___________________________________

Describe any stressors occurring at the time____

What activities provide relief?_________________________**what makes it worse?**___________________________________

Is this condition getting worse?______________________**interfere with work**______**sleep**______ **recreation**__________

Describe your exercise routine (type, frequency)____

FAMILY HISTORY

Alive? ***Age/Cause of Death*** ***Major Health Issues***

Mother:____

Father:____

Siblings:____

Maternal Grandmother____

Maternal Grandfather____

Paternal Grandmother____

Paternal Grandfather____

Family History of Abuse________***circle if applicable*** **: physical emotional sexual spiritual**

Family History of Substance Abuse__________**Suicide**_____________ **Other Trauma**______________________________

DIGESTION & ELIMINATION

Typical Breakfast:____

Typical Lunch:____

Typical Dinner:____

Snacks:____________________________**Water Intake(glasses/day)**__________________**Caffeine**_________________

What is the worse thing on your diet__________________**What foods are your weakness**________________________

Are you subject to binge eating?__________________**What foods**____

Do you experience bloating/gas/burps after eating?____**What foods trigger this?**______________________________

How often are your bowel movements?_____________________________**Do your stools: sink**______**float**________

Constipation?_____________**Blood in stool ?**__________**Mucus in stool?**_____________**Pain when stooling?**__________

Other concerns____

EMOTIONAL & SPIRITUAL

What is your opinion of yourself?____

If possible, please describe the most negative emotion you experience____

When do you most often feel this emotion:_____________________**Where are you?**_____________________________

Do you pray to or have a spiritual practice____

On a scale of 1 – 10 ***(1 being the lesser, 10 the greater***) **Please rate yourself:**
Faith______________**Hope**________________**Charity**_________**Generosity**___________ **Sense of Humor**_____________
Sense of Fun______________**Fear**__________**Grief**_________**Other (describe briefly)**______________________________

What are hobbies/ activities that provide you with a sense of pleasure and accomplishment________________________

What changes would you like to achieve in 6 months_______________________**One Year**__________________________

MEDICAL HISTORY

Are you currently under the care of another health care provider(s)?__________________**Reason (s)**_______________

____

Name(s) of
Practitioner_______________________________**Address:**____

Phone____**email**____

Current Medications:____

____

Allergies: specify allergen and reaction:____

Supplements/Remedies____

____

Do you use Tobacco?______ Quantity_____/ppd Alcohol?______Quantitiy______ounces/ day
Marijuana?________Quantity______Other:____________________Have you been under treatment for substance use?

If so, describe:____

Surgical History (year and type)____

____

Recent Procedures:____

Hospitalizations ____

____

Accidents or Traumas____

Falls/Injuries to Sacrum/head/tailbone (describe)____

Birth Trauma if known ____

Circle any of the following you are *Currently* experiencing
Underline and of the following you have experienced in the *Past*

Headaches (migraine, tension, cluster) Ringing in Ears Pins and needles in arms, legs, hands or feet

Asthma Cold Hands or Feet Swollen ankles Sinus Conditions Seizures

Loss of Smell or Taste Skin Disorders: *Acne, Fungus, Psoriasis Other*:______________________________________

Sciatica Painful Joints Swollen Joints Spinal Problems Anxiety Fatigue

Trouble Sleeping Fainting Spells Loss of Memory Depression

Muscular Tightness: (location) ____________________________ Varicose Veins (location)________________________

Herniated or Bulging disc: (location)________________________________High or Low Blood Pressure

Contact lenses Dentures Artificial /Missing limbs Frequent Colds/ Upper Respiratory conditions

Mark Any areas of current persistent pain or tension on the figures below:

FEMALE ~ REPRODUCTIVE HEALTH HISTORY

Age of Menarche____________What was this like for you____

How many Pregnancie(s) have you had?________________Number of Deliverie(s)__________Dates_______________

Termination(s)______________When____

Miscarriage(s)?______________When____

Complications____

What was your experience of: *Pregnancy*____
***Labor*____**
***Delivery*____**
***Post Partum*____**

Medications your mother took when she was pregnant with you (if any)____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis------
Cancer(type)______________________Menstrual Problems Menopause PMS

Method of Contraception (circle) pills patch diaphram injection condoms IUD abstinence rhythm method
Other:______________

Length of time on synthetic contraception (Pill, Patch or Injection):____

Last Pap smear______________Results (if known)____

Date of Last Menstrual period________________ Length of Menses____

Episodes of Amenorrhea____________When_________For how long____

Please circle as appropriate:

Painful periods
Dark Thick Blood at Beginning or End of Cycle
Headache or Migraine with period
PMS/Depression with or before period
Painful Ovulation
Heaviness or pressure in lower pelvis with period
Irregular (late or early)
Dizziness with period
Excessive Bleeding (> one pad/hour)
Failure to Ovulate
Bloating/water retention with period

Other Symptoms *(Circle and Describe as indicated)*

Varicose veins of leg
Numb legs and feet when standing still
Low back ache
Constipation
Endometritis
Tired weak legs
Sore heels when walking
Painful intercourse
Endometriosis
Uterine Polyps
Fibroids (Size and Location if known)____
Uterine infections
Bladder infections
Vaginitis
Chronic miscarriages
Weak newborn infants
Incompetent cervix
Pelvic Inflammation
Dry vagina (without menopause)
Cancer(cervix, bladder, uterus, ovarian, bladder, bowel)
Frequent urination
Vaginal discharge (describe)
Vaginal Yeast infections
Premature deliveries
Difficult pregnancy
Spotting with pregnancy
Sexually Transmitted Disease (date and type)___________
Difficult menopause
Cysts (ovarian breast)

Are you under the treatment for Infertility______Describe current treatment to date :___________________________ (IUI, IVF,etc)____

Gynecological Provider:___________________Address______________________________________Phone_____________

Rate your interest in Sex: High___________Moderate___________Low_______________None_____________________

Do you have or ever had difficulty experiencing orgasms____

Have you experienced a history of rape________trauma________incest__If so,-when______________________________

Did you undergo counseling for this____

What was this like for you____

MENOPAUSE ***(Circle the symptoms that apply to you)***

Hot flashes	**Insomnia**	**Fatigue**	**Memory Loss**
Mood swings	**Irritability**	**Vaginal discharge**	**(*describe*):**
Dry Vagina	**Fatigue**	**Depression**	**Spotting (menses)**
Flooding	**Clotting**	**Irregular menses**	**Increased/Decreased Libido**

Other symptoms not listed above____

____

When did these symptoms begin:____

Are they getting worse_______better_________same_________Last Menstrual period________________________________

Are you on/ or ever been on hormone replacement therapy?_______if so, how long_______________________________

Name and dose____

Reason for stopping____

Other medications/herbal remedies____

Age of Mother at menopause:______Concerns/Experience____

Additional Comments:

MALE ~ REPRODUCTIVE HEALTH HISTORY

Circle and Describe those symptoms as applicable

Headaches: Migraine_____Tension______Cluster_______ Low back pain Sore heels
Varicose Veins ______Location____
Numbness in legs/feet Depression Anxiety Irritability

Family History of Prostate Disease:________Type_______________Relationship____________________________

Family History of Cancer__________________Type_______________Relationship____________________________

History of sexually transmitted disease____________When_________Type___________________________________

Rate your interest in Sex: High___________Moderate____________Low____________None_________________

Do you have or ever had difficulty experiencing orgasms____

Have you experienced a history of rape_______trauma_______incest__If so,-when____________________________

Did you undergo counseling for this____

What was this like for you____

Urinary Symptoms (*circle those applicable*)

Painful urination Bladder/Kidney infections
Frequent Urination Nocturnal Urination/ Frequency________
Changes in urinary stream (describe flow, stream, strength of stream)____________________________

When did you first notice these symptoms____

Are they getting better or worse____________Describe____

Erectile Function(*describe as indicated*)

Difficulty obtaining an erection Difficulty maintaining an erection Painful ejaculation

Is there a history of back injury/trauma__________Describe:____

When did you first notice these symptoms____

Are they getting better or worse____________Describe____

Current Medications or Supplements:____

____

Results of PSA (prostate specific antigen) Test if known_____________ Date done____________________________

Results of Sperm count (if applicable and known)___________________________________Date done____________

Additional Comments:

Please read and sign

I understand that payment is due at the time of treatment unless arrangements have been made other wise.

I agree to give at least 48hours notice of cancellation of appointment otherwise full session fee will be owed. Cases of extreme emergency are considered exceptions to this cancellation policy.

I understand the treatment here is not a replacement for medical care.

I understand the therapist/practitioner does not diagnose medical illness, disease or any other physical or mental conditions (unless specified under his/her professional scope of practice)

As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice)

I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.

I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Client signature____Date______________________________

Therapist/Practitioner signature:_______________________________________Date_______________________________

Client Confidentiality Release Form

I, (name)____address ______________________________________

Phone____email____

give my permission, for my therapist/practitioner, ____

to take notes about me, including health history/ medical and /or personal information I choose to disclose to him/her.

I also understand that this information will anonymously be used for the Arvigo Institute, LLC . for statistical purposes, and that my practitioner may use this information to provide me with a summary for my own personal use.

Signature: ____ Date: ____________________________
Revised on 08/21/2008

Mail all intake forms to:
Samantha Ford, CMT
PO Box 6684
Albany, CA 94706
USA