Confidential Client Intake Form

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

Address____**State**___________________**Zip**__________________

Home Phone___________________________**Work Phone**___________________**email**______________________________

Date of Birth____________**Age**_________**Occupation**____

Marital/Relationship status____________________________**Referred by**____

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

Reason For Visit

Primary reason for visit:____

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**________

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 and /orSupplements/Remedies:____

____

Allergies: specify allergen and reaction:____

Surgical History (year and type) and/or Recent Procedures:____

____

Hospitalizations ____

____

Accidents or Traumas____

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

Other:

Please review and check the following:

Headaches Type:	Past Present	Pins and Needles in arms, legs, Hands or feet	Past Present
Asthma		Spinal Problems	
Cold Hands or feet		Anxiety	
Swollen ankles		Depression	
Sinus Conditions Frequent Colds		Sleep Disturbance	
Seizures		Fainting Spells	
Loss of smell or Taste		Loss of Memory	
Skin Disorders: Type		Varicose Veins Hemorrhoids Location	
Sciatica		Muscular Tension: Location:	
Painful/Swollen Joints		Herniated/Bulging Discs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Artifical/Missing limbs	

Other (not mentioned above)

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

Family History

	Still Living?	Cause of Death/age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Other:

Digestion and Elimination

Typical Breakfast:____

Typical Lunch:____

Typical Dinner:____

Snacks:______________________**Water Intake(glasses/day)**__________**Caffeine**__________

What is the worst item in 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________________

Describe your exercise routine (type, frequency)________________________________

What changes would you like to achieve in 6 months______________**One Year**______________

Female Reproductive Health History

When did you begin your menses________**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)______________________

Birth Trauma if known ____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis------PMS Menopause

Cancer(type)____________________Menstrual Problems Other____

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

Fertility Awareness Other:_____________Length of time using method____

Last Pap smear_____________Results (if known)____

Date of Last Menstrual period_______________ Length of Menses______ Are you Pregnant/Trying to Conceive_____________

Episodes of Amenorrhea___________When________For how long____

Please check as appropriate:

Painful Periods	**Irregular Cycles (early or late)**
Dark, thick blood at beginning of cycle cycle	**Dark thick blood at the end of cycle**
Headache or Migraine with period	**Dizziness with period**
Bloating/Water Retention with period	**Heaviness in pelvis with period**
PMS/Depression with or before period	**Excessive Bleeding (> one pad/hour)**
Failure to Ovulate	**Painful Ovulation**
Varicose Veins	**Tired weak legs**
Numb legs and feet when standing	**Sore heels when walking**
Low back ache	**Painful intercourse**
Constipation	**Endometriosis**
Endometritis/Uterine Infections	**Uterine Polyps**
Fibroids	**Vaginal Discharge/Vaginitis/**
Bladder Infections/Incontinence	**Chronic Miscarriage**
Weak newborn infants	**Premature deliveries**
Incompetent cervix	**Spotting with pregnancy**
Pelvic Inflammation	**Sexually Transmitted disease**
Dry Vagina	**Difficult menopause**
Cancer esp of reproductive area	**Cysts esp breast/ovarian**
Other:	

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 (Check the symptoms that apply to you)

Hot flashes	**Insomnia**	**Fatigue**	**Memory Loss**	**Mood Swings**
Vaginal Discharge	**Dry Vagina**	**Depression**	**Anxiety**	**Irritability**
Spotting	**Flooding**	**Irregular Menses**	**Painful Intercourse**	**Increased Libido**
Decreased Libido	**Disturbed Sleep Pattern**			

Age symptoms began:_________Are they getting worse______________better___________________same_________

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

Name and dose____

Reason for stopping____

Age of Mother at menopause:______Concerns/Experience____

Additional Comments:

Client Confidentiality Release Form

I understand that payment is due at the time of treatment unless arrangements have been made other wise.
I agree to give at least 24hourse notice of cancellation of appointment.
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________________________________

Due to the HIPAA regulations all practitioners should have a signed release form from their client *before* taking any notes about them. The best way to be fully compliant is to obtain this release signature at the initial consultation.
Certification candidates should have this form signed before taking any notes. Clients should receive a copy of the form they signed, and the practitioner maintains a copy for their records
Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance.
Failure to comply with these confidentiality regulations could result in penalties.
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 understand that this information may be used for the purpose of practitioner certification and will be shared with the Arvigo Institute, LLC .

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 01/22/04