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CONFIDENTIAL CLIENT INTAKE FORM-Female

Name:____Date of Initial Visit ______________________

Address____State______________________Zip______________________

Home Phone______________________Work Phone__________________ Cell 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

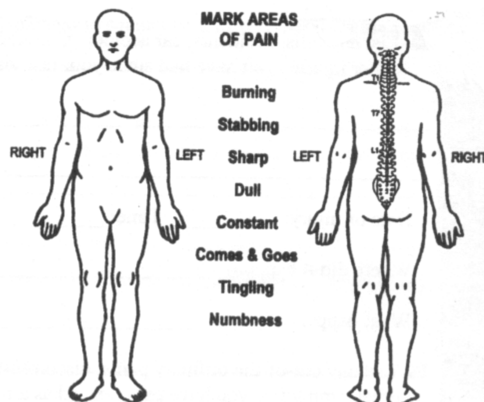
Trouble Sleeping Fainting Spells Loss of Memory Depression

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:

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 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 medcial 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

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 would be to get 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