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CONFIDENTIAL CLIENT INTAKE FORM-Males

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

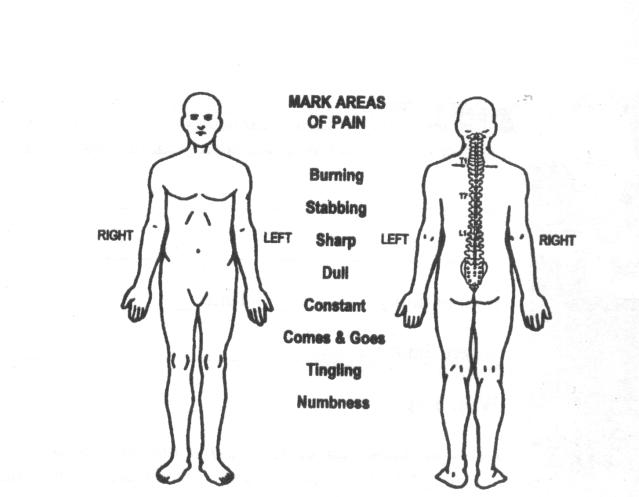
Trouble Sleeping Fainting Spells Loss of Memory Depression

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:



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 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