



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

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)

Tired weak legs

Sore heels when walking

Painful intercourse

Endometriosis

Uterine Polyps

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
Mood swings
Dry Vagina
Flooding

Insomnia
Irritability
Fatigue
Clotting

Fatigue
Vaginal discharge
Depression
Irregular menses

Memory Loss
(describe):
Spotting (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 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: _____