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Intake Form for Holistic Massage Therapy & Arvigo Techniques of Maya Abdominal Therapy®

Client # _____

Basic Contact Information

Name _____ Date of Initial Visit _____

Address _____

City _____ State _____ Zip _____ Phone _____

Email _____ Best way to contact you? email call text

Date of birth _____ Age _____ Occupation _____

How/who did you hear about Hands with Heart? _____

Emergency Contact

Name _____ Phone _____ Relationship _____

Client Confidentiality and Release Form

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations (unless specified under his/her professional scope of practice). The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client *before* taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records.

I, **(print name)**_____ give my permission, for my practitioner to take notes including health history/ medical and /or personal information I choose to disclose to him/her. I understand this information may be be shared with the Arvigo Institute, LLC for statistical data collection only. All relevant identifying information will not be disclosed, such as name, address, social security number, date of birth.

Client Signature _____ **Date** _____

Practitioner _____**Date** _____

Reason for Visit

Primary reason for visit _____

When did you first notice it? _____

Do you know what may have triggered it? _____

Describe any stressors occurring at the time _____

What activities provide relief?_____

What makes it worse?_____

Is this condition getting worse better same Interferes with work sleep recreation

Have you recieved massage before? yes no If so, how often?_____

Pressure preference: light medium deep Are you sensitive to fragrances? yes no

Do you have difficulty lying on your front, back, or side? yes no If so, explain _____

Medical History

Are you under the care of another healthcare provider(s)? If so, why?_____

_____

Name and type of practitioner(s) _____

Practitoner address _____

Phone _____ Email _____

Current medications, supplements, and/or remedies _____

_____

Allergies (allergen & reaction) _____

Surgical history & recent procedures(year and type) _____

_____

Hospitalizations, accidents, or traumas _____

_____

Falls or injuries to sacrum, head, tailbone (describe) _____

_____

How many hours a night do you sleep? _____ How is the quality of your sleep? _____

Please review and check the following:

	Past	Present		Past	Present
Anxiety			High or low blood pressure		
Asthma			Low back pain		
Autoimmune condition			Muscular tension (location?)		
Cancer (type?)			Numbness in feet or legs when standing		
Cold Hands or feet			Painful or swollen joints		
Dentures or partials			Sciatica		
Depression			Seizures		
Diabetes (type?)			Sinus conditions / frequent colds		
Fainting spells			Skin conditions (type?)		
Headaches (type?)			Sleep distrubance		
Heart condition (type?)			Sore heels when walking		
Hemorrhoids			Swollen ankles		
Herniated/bulging discs			Varicose veins (location?)		

Additional conditions or descriptions of conditions listed above _____

_____

Dietary/Digestive Health

Describe your typical:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Water (oz/day) _____ Caffeine (oz/day) _____ What foods do you crave? _____

Are you subject to binge eating? If so, what foods? _____

What are your eating habits in times of stress? _____

Do you have history of eating disorders? If so, describe _____

Experience bloating/gas/burps after eating? _____ What foods trigger this? _____

Do you have food allergies/sensitivities/intolerances? yes no Describe _____

How often are your bowel movements? _____

Constipation? yes sometimes no Diarrhea? yes sometimes no Blood in stool? yes sometimes no

Mucus in stool? yes sometimes no Pain with elimination? yes sometimes no Other _____

Family of Origin History

	Still Living?	Cause and age of death	Major health issues	In a few words, describe your personal relationship & feelings toward this person
Mother	yes no			
Father	yes no			
Siblings (older/younger?)	yes no			
Maternal Grandmother	yes no			
Maternal Grandfather	yes no			
Paternal Grandfather	yes no			
Paternal Grandmother	yes no			

Lifestyle, Emotional, and Spritual Health

What is your opinion of yourself? _____

Describe the most positive emotion you experience _____

When and where do you experience this emotion? _____

Describe the most negative emotion you experience _____

When and where do you experience this emotion? _____

What activities provide you with joy & fullfillment? _____

_____

Describe your relationship status and/or support system _____

_____

Describe your spiritual/religious practice _____

Describe your exercise routine (type, frequency) _____

What changes would you like to achieve in 6 months? _____

One year? _____

Do you use Tobacco?____ Quantity _____/day week month Alcohol?____ Quantity _____/day week month

Marijuana?____ Quantity _____/day week month Other? _____

Have you ever been under treatment for substance use? _____

Male Reproductive Health History

Please check the symptoms below that apply:

	Past Present		Past Present
Bladder or kidney infections (when?)		Pain/discomfort in inner thighs: Left Right Both	
Blood or pus in urine		Pain/discomfort in: Penis / Testicles / Rectum	
Difficulty obtaining or maintaining erection		Painful ejaculation	
Difficult starting or holding urine stream		Painful Urination	
Insatiable sex drive		Pelvic pressure	
Lower back pain after intercourse		STD (type?)	
Nocturnal urination (# of times?)		Urinary incontinence or dribbling	
Pain or burning with urination		Urinary Retention	
Pain/discomfort between scrotum and testicles		Weak or interrupted urine flow	

Results of PSA/Prostate Specific Antigen Test (if known) _____ Date done _____

Results of sperm count (if applicable and known) _____ Date done _____

Family history of prostate disease? yes no Type _____ Relationship _____

Family history of cancer? yes no Type _____ Relationship_____

Rate your interest in sex (please circle): High Moderate Low None

Do you have or ever had difficulty experiencing orgasms?_____

The following questions are of sensitive nature. Only answer what you feel comfortable answering. The pelvis and abdomen are especially vulnerable places that tend to store held emotions. Therefore, it is helpful to know your history of trauma so that we can create the safest and most respectful enviroment possible for you.

Have you experienced trauma (sexual, physical, emotional, verbal, or otherwise?) yes no

Did you undergo counseling for this? yes no How do these experiences effect you today? _____

_____

Additional pertinent Information you feel important that your practitioner should know that is not mentioned on this intake form: