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

Client # _____

Basic Contact Information

Preferred 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.

Legal Name Printed _____

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

Gender assigned at birth _____ Gender currently identifying as _____

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? _____

Womb Centered Health

Method of contraception (please circle)

Pills Patch Diaphragm Injection Condoms IUD Abstinence Rhythm Method Fertility Awareness/NFP

Other _____ Length of time using method _____ Last Pap smear _____Results _____

Are you trying to conceive? yes no Are you pregnant? yes no unsure

Are you currently or have you in the past experienced fertility challenges? yes no

Describe your treatment _____

Menstrual History

Age of first menses _____ What was this like for you? _____

Last menstrual period started on ____ / ____ / ____ Length of last menstrual period _____

Typical menstrual period length _____ Typical full cycle length _____

	Past	Present		Past	Present
Amenorrhea episodes (how long?)			Irregular cycles (early or late?)		
Back/sciatic/hip pain during menses			Painful intercourse		
Bladder infections			Painful ovulation		
Bloating			Painful periods		
Cysts (location?)			Prolapse		
Dark thick blood (start, end, or both?)			Scant Bleeding		
Diarrhea during menses			STD (type?)		
Dizziness			Tilted/displaced uterus (location?)		
Endometriosis (location?)			Urinary Incontinence		
Excessive bleeding (pads per hour?)			Uterine infections		
Failure to ovulate			Uterine or cervical polyps		
Fibroids (location? type?)			Vaginal dryness		
Headache or migraine with menses			Vaginal infections		
Heaviness in pelvis prior to menses			Water retention		

Additional conditions or descriptions of conditions listed above _____

_____

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? _____

_____

Pregnancy History

Pregnancies: # _____ Dates _____ Miscarriages: # _____ Dates _____

Terminations: # _____ Dates _____ Births: # _____ Dates _____

Describe complications for any of the above _____

Premature Births? ____ Spotting While Pregnant? ____ Weak Newborns? ____ Incompetent Cervix? ____

Describe your experience with:

Pregnancy:_____

Labor:_____

Birthing:_____

Post Partum:_____

Maternal Family History of (*please circle*)

Infertility Fibroids Endometriosis PMS Menopausal Issues Cancer (type _____)

Menstrual problems _____ Other _____

Medications your mother took while pregnant with you (if any) _____

Your Birth Trauma (if known) _____

Perimenopause, Menopause, & Transitioning

Age symptoms began _____ Are they getting worse better same

Are you on or ever been on hormone replacement therapy? yes no How long? _____

Name and dosage: _____

Reason for stopping: _____

Check the following symptoms that apply to you:

Anxiety		Insomnia		Painful intercourse	
Depression		Irregular menses		Spotting	
Disturbed sleep pattern		Irritability		Urine leakage when coughing or sneezing	
Fatigue		Libido (increased/decreased?)		Urinary urgency	
Flooding menses		Memory loss		Vaginal discharge	
Hot flashes		Mood swings		Vaginal dryness	

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

Prostate Centered Health

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_____

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