

Confidential Client Intake Form

Name: _____ Date of Initial Visit _____
Address _____ State _____ Zip _____
Home Phone _____ Work Phone _____ email _____
Date of Birth _____ Age _____ Occupation _____
Marital/Relationship status _____ Referred by _____
Have you had massage/bodywork before? _____ What type? _____

Reason For Visit

Primary reason for visit: _____
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 _____

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 and /orSupplements/Remedies: _____

Allergies: specify allergen and reaction: _____
Surgical History (year and type) and/or Recent Procedures: _____

Hospitalizations _____

Accidents or Traumas _____
Falls/Injuries to Sacrum/head/tailbone (describe) _____
Other:

Please review and check the following:

Headaches Type:	Past	Present	Pins and Needles in arms, legs, Hands or feet	Past	Present
Asthma			Spinal Problems		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Loss of smell or Taste			Loss of Memory		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Muscular Tension: Location:		
Painful/Swollen Joints			Herniated/Bulging Discs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Artificial/Missing limbs		

Other (not mentioned above)

Do you use Tobacco? _____ Quantity _____/ppd Alcohol? _____ Quantitiy _____ ounces/ day
 Marijuana? _____ Quantity _____ Other: _____ Have you been under treatment for substance use?

Family History

	Still Living?	Cause of Death/age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Other:

Digestion and Elimination

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____ Water Intake(glasses/day) _____ Caffeine _____

What is the worst item in 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 _____

Describe your exercise routine (type, frequency) _____

What changes would you like to achieve in 6 months _____ One Year _____

Female Reproductive Health History

When did you begin your menses _____ 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) _____

Birth Trauma if known _____

Maternal Family History of (please circle) Infertility Fibroids Endometriosis-----PMS Menopause

Cancer(type)_____ Menstrual Problems Other_____

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method

Fertility Awareness Other:_____ Length of time using method_____

Last Pap smear_____ Results (if known)_____

Date of Last Menstrual period_____ Length of Menses_____ Are you Pregnant/Trying to Conceive_____

Episodes of Amenorrhea_____ When_____ For how long_____

Please check as appropriate:

Painful Periods	Irregular Cycles (early or late)
Dark, thick blood at beginning of cycle cycle	Dark thick blood at the end of cycle
Headache or Migraine with period	Dizziness with period
Bloating/Water Retention with period	Heaviness in pelvis with period
PMS/Depression with or before period	Excessive Bleeding (> one pad/hour)
Failure to Ovulate	Painful Ovulation
Varicose Veins	Tired weak legs
Numb legs and feet when standing	Sore heels when walking
Low back ache	Painful intercourse
Constipation	Endometriosis
Endometritis/Uterine Infections	Uterine Polyps
Fibroids	Vaginal Discharge/Vaginitis/
Bladder Infections/Incontinence	Chronic Miscarriage
Weak newborn infants	Premature deliveries
Incompetent cervix	Spotting with pregnancy
Pelvic Inflammation	Sexually Transmitted disease
Dry Vagina	Difficult menopause
Cancer esp of reproductive area	Cysts esp breast/ovarian
Other:	

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 (Check the symptoms that apply to you)

Hot flashes	Insomnia	Fatigue	Memory Loss	Mood Swings
Vaginal Discharge	Dry Vagina	Depression	Anxiety	Irritability
Spotting	Flooding	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Age symptoms began: _____ Are they getting worse _____ better _____ same _____

Are you on/ or ever been on hormone replacement therapy? _____ if so, how long _____

Name and dose _____

Reason for stopping _____

Age of Mother at menopause: _____ Concerns/Experience _____

Additional Comments:

Client Confidentiality Release Form

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 medical 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 _____

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 is to obtain 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