The Arvigo Techniques of Maya Abdominal Therapy™ =
Craniosacral Therapy and Massage Therapy
Confidential Intake Form

"SECTION A"

Date of Initial Visit_____

Name:_____

Address_____

City_____State_____Zip_____

Email:_____

Home Phone_____Cell_____

Date of Birth_____Age_____Occupation_____

Marital/Relationship status_____Referred by_____

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, (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 used for the purpose of practitioner certification and/or may 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 signature_____Date:_____

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_____

Have you had massage/bodywork before?_____ What type?_____

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	Numbness in feet or legs when standing	Past Present
Asthma		Sore heels when walking	
Cold Hands or feet		Anxiety	
Swollen ankles		Depression	
Sinus Conditions Frequent Colds		Sleep Disturbance	
Seizures		Fainting Spells	
Low Back Pain		Muscular Tension: Location:	
Skin Disorders: Type		Varicose Veins Hemorrhoids Location	
Sciatica		Herniated/Bulging Discs	
Painful/Swollen Joints		Artifical/Missing limbs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Cancer (past or current) Type	

Family History

	Still Living?	**Cause and Age of Death**	**Major Health Issues**
Mother			
Father			
Siblings			
Maternal Grandmother			

Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Gastroinstestinal Health History

Describe your typical:

Breakfast:_____

Lunch:_____

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?_____

Food Allergies?_____Describe_____

How often are your bowel movements?_____Do your stools: sink_____float_____

Constipation?_____Blood in stool ?_____Mucus in stool?_____Pain when stooling?_____

Diarrhea?_____Other?

_____

Lifestyle, Emotional & Spiritual

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?

_____

Describe your Spiritual and/or Religious practice:_____

On a scale of 1 – 10 *(1 being the lesser, 10 the greater*) Please rate yourself in each of these qualities:

Faith_____Hope_____Charity_____Generosity_____Sense of Humor_____Fear_____Grief_____Sense of Fun_____

What hobbies/ activities provide you with pleasure and accomplishment_____

Describe your exercise routine (type, frequency)_____

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

One Year:_____

Do you use Tobacco?_____ ounces/ day

Marijuana?_____Quantity_____ treatment for substance use?

Female Reproductive Health History

"SECTION B"

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 _____

Are now or in the past experiencing Fertility Challenges? Yes___No___Describe your treatment :_____

(IUI, IVF,etc)_____

Menstrual History Review and check as indicated:

Age of Menses:_____What was this like for you? _____

Last Menstrual Period:_____Length of Menses_____

Are you trying to Conceive? Yes_____No_____ Are you Pregnant? Yes____No____Unsure____

Painful Periods	Past Present	Irregular cycles Early Late	Past Present
Heaviness in Pelvis prior to menses		Dark Thick Blood at: Beginning End Both	
Excessive Bleeding Pads per Hour		Headache or Migraine with menses	
Dizziness		Bloating	
Water Retention		Ovulation: Painful Failure to	
Endometriosis Location (if known)		Fibroids Location (if known)	

Uterine or Cervical Polyps		Uterine Infection(s)	
Vaginal Infection(s)		Cysts Location:	
Bladder Infection(s)		Urinary Incontinence	
Painful Intercourse		Vaginal Dryness	
Episodes of Amenorrhea How long?			

Rate your interest in Sex:
High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced trauma?
Yes___No____Describe_____

Did you undergo counseling for this_____

What was this like for you_____

Pregnancy History

Number of Pregnancies:_____Dates_____Miscarriage(s)_____Dates_____Termination(s)_____Dates:_____

Number of Births:_____
Dates:_____

Complications for any of the above, describe:_____

Premature Births?_____Spotting During Pregnancy?_____Weak Newborns?_____Incompetent Cervix? _____

Describe your experience with:

Pregnancy:_____
_____

Labor:_____
_____

Birthing_____
_____

Post Partum:_____
_____

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

Cancer(type)_____Menstrual Problems _____Other_____

Medications your mother took when she was pregnant with you (if any)_____

Your Birth Trauma (if known)
_____

Menopause

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_____

Check the following 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			

Additional Information you feel important your practitioner should know that is not mentioned here:

Male Reproductive Health History

Please check the symptoms below that apply

Painful Urination	Past	Present	Urinary Retention	Past	Present
Urinary Incontinence or Dribbling			Difficult starting or holding urine stream		
Weak or Interrupted Urine flow			Blood or pus in urine		
Pain or Burning with Urination			Pelvic pressure		
Nocturnal Urination How many times?			Insatiable sex drive		
Pain in lower back, esp After intercourse			Pain or Discomfort Between scrotum and Testicles		
Pain or Discomfort in: Penis Testicles Rectum			Pain or Discomfort in Inner thighs: Left Right Both		
Frequent Bladder or Kidney Infections When?			Erection: Difficulty in Obtaining Maintaining Painful ejaculation		

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_____

Sexually transmitted disease Yes___No___Type if Known_____

Rate your interest in Sex:
High_____Moderate_____Low_____None_____

Do you have a history of trauma: describe_____

Did you undergo counseling for this_____

What was this like for you_____

Additional Comments: