

## 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:

<b>Painful Periods</b>	<b>Irregular Cycles (early or late)</b>
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