# Confidential Intake Form

Date of Initial Visit_____

Name:_____

Address_____

State_____Zip_____Home Phone_____

Work Phone_____Cell_____email_____

Date of Birth_____Age_____

Occupation_____

Marital/Relationship status_____Referred by_____

## 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_____

HIPAA regulations require 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. Practitioners should have this form signed before taking any notes. Clients should receive a copy of the form they signed (upon request), 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 _____

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 this information may be used for the purpose of practitioner certification and will be shared with the Arvigo Institute, LLC .

I understand that this information will anonymously be used for the Arvigo Institute, LLC . for statistical purposes only, and that my practitioner may use this information to provide me with a summary for my own personal use.

Signature: _____ Date: _____

Revised on 04/22/08

**Client Initials:** _____**Case Study #**_____

**Date of Visit:**_____**Age**_____**Male**_____**Female**_____

## 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/or Supplements/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:**

| | Past | Present | | Past | Present |
|---|---|---|---|---|---|
| **Headaches Type:** | | | **Pins and Needles in arms, legs, Hands or feet** | | |
| **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** | | | **Artifical/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** | | | |

## 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 Pregnancy (s) have you had?_____Number of Birth-(s)_____Dates_____**

**Termination(s)_____When_____**

**Miscarriage(s)_____When_____**

**Complications_____**

**What was your experience of: *Pregnancy* _____**

***Labor*_____**

***Birthing*_____**

***Post Partum*_____**

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

**Birth Trauma (if known) _____**

**Method of Contraception (circle) pills patch diaphram 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_____**

**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_____**

**Please check as appropriate, time-period: last 6 months:**

| | Past | Present | | Past | Present |
|---|---|---|---|---|---|
| Painful Periods | | | Irregular Cycles (early or late) | | |
| Dark, thick blood at beginning of 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: | | | | | |

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

**Cancer(type)_____Menstrual Problems _____ Other_____**

## 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 currently:**

| | | | | |
|---|---|---|---|---|
| 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 Comments:**