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: