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 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

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 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, ss number, date of birth..

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 04/23/08

Client I
Client I **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 /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:

Page 2. 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		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 Grandfather			
Paternal Grandmother			

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:

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:	

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:

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: