Confidential Client Intake

Date of Initial Visit_____

Name: _____

Address_____

State _____ Zip _____Home Phone_____

Work Phone_____Cell_____email_____

Date of Birth _____ Age _____

Female _____ Male_____ Other_____ Preferred Pronoun_____

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) _____address _____

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:_____

For Administrative Use Only

Client Initials: _____Case Study #_____Age_____ Anatomy: Male _____ Female_____

Date of Visit: _____ Practitioner Name_____

Reason For Visit

Primary reason for visit: _____

When did your first notice it? _____What brought it n? _____

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:

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			Artificial/Missing limbs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Cancer (past or current) Type		

Other (not mentioned above):

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**_____

Do you use Tobacco? _____ **Quantity**_____**/ppd** **Alcohol?** _____ **Quantity** _____**ounces/day**

Marijuana? _____**Quantity** _____**Other:** _____**Have you been under treatment for substance use?**

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: _____

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method

Reproductive Health History - Female Anatomy

Last Pap smear _____ Results (if known) _____

Are you under the treatment for Infertility _____Describe current treatment to date: _____

(IUI, IVF, etc.)_____

Gynecological Provider: _____Address_____Phone_____

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? _____Possibility of Pregnancy_____

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?			

Pregnancy History:

Number of Pregnancies: Number of Births: Dates:	Complications:	Miscarriages:	Terminations:
Premature Births:	Spotting during Pregnancy	Weak Newborns at Birth	Incompetent Cervix

Briefly 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) _____

Other:

Rate your interest in Sex: High_____**Moderate**_____**Low**_____**None**_____

Do you have or ever had difficulty experiencing orgasms_____

Do you have a history of rape _____**trauma** _____**incest** ____**If so,-when**_____

Did you undergo counseling for this? _____

What was this like for you _____

Please feel free to share any additional information:

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:

Reproductive Health History - Male Anatomy

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 rape _____**trauma** _____**incest** _____ **If so, when?** _____

Did you undergo counseling for this? _____

What was this like for you _____

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