Confidential Intake Form

Practitioner: DO NOT send this page with your case study report – for your records ONLY

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

Fertility Awareness   Other: _____________Length of time using 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: