

Confidential Intake Form

Date of Initial Visit _____
Name: _____
Address _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell _____
Date of Birth _____ Age _____ Email _____
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 24hour 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

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

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: _____

Please review and check the following:

	Past	Present		Past	Present
Headaches			Pins and Needles in arms, legs,		
Type:			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:			Varicose Veins		
Type:			Hemorrhoids		
			Location:		

	Past	Present		Past	Present
Sciatica			Muscular Tension:		
Painful/Swollen Joints			Location:		
High or Low Blood Pressure			Herniated/Bulging Discs		
Dentures/Partials			Contact Lenses		
			Artificial/Missing limbs		

Other (not mentioned above): _____

Do you use:

	Yes	No	Quantity	
Tobacco?			_____	/ppd
Alcohol			_____	ounces/day
Marijuana			_____	
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			

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 AND 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:

1 2 3 4 5 6 7 8 9 10

- 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 AND 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) _____ Date(s) _____

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 (check)

Pills	Patch	Diaphragm	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

Dark, thick blood at beginning of cycle

Headache or Migraine with period

Bloating/Water Retention with period

PMS/Depression with or before period

Failure to Ovulate

Varicose Veins

Numb legs and feet when standing

Low back ache

Constipation

Endometritis/Uterine Infections

Fibroids

Bladder Infections/Incontinence

Weak newborn infants

Incompetent cervix

Pelvic Inflammation

Dry Vagina

Cancer esp of reproductive area

Other: _____

Irregular Cycles (early or late)

Dark thick blood at the end of cycle

Dizziness with period

Heaviness in pelvis with period

Excessive Bleeding (> one pad/hour)

Painful Ovulation

Tired weak legs

Sore heels when walking

Painful intercourse

Endometriosis

Uterine Polyps

Vaginal Discharge/Vaginitis/

Chronic Miscarriage

Premature deliveries

Spotting with pregnancy

Sexually Transmitted disease

Difficult menopause

Cysts esp breast/ovarian

Maternal Family History of (please check)

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: