

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

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

Client Initials _____	Date of Visit _____	Case Study # _____
Practitioner Name _____		Age _____

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:

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			Artificial/Missing limbs		

Other (not mentioned above)

Do you use Tobacco? _____ Quantity _____/ppd Alcohol? _____ Quantity _____ 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			

Other:

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 Pregnancie(s) have you had? _____ Number of Deliverie(s) _____ Dates _____

Termination(s) _____ When _____

Miscarriage(s)? _____ When _____

Complications _____

What was your experience of: *Pregnancy* _____

Labor _____

Delivery _____

Post Partum _____

Medications your mother took when she was pregnant with you (if any) _____

Birth Trauma if known _____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis-----PMS Menopause

Cancer(type) _____ Menstrual Problems Other _____

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 _____

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:	

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 _____

Menopause (Check the 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			

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 _____

Additional Comments: