

### Maya Abdominal Massage 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 Erin Aufdemberge, Registered Massage Therapist, to take notes about me, including health history/ medical and /or personal information I choose to disclose to 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: \_\_\_\_\_

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:**

	<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pins and needles in arms, legs, hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____			Spinal problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Sinus conditions/frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell or taste	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Skin disorders	<input type="checkbox"/>	<input type="checkbox"/>	Location: _____		
Type: _____			Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Muscular tension	<input type="checkbox"/>	<input type="checkbox"/>
Painful/swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	Location: _____		
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Herniated/bulging discs	<input type="checkbox"/>	<input type="checkbox"/>
Dentures/partials	<input type="checkbox"/>	<input type="checkbox"/>	Artificial/missing limbs	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>			

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 and Age	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* \_\_\_\_\_

*Birth* \_\_\_\_\_

*Post Partum* \_\_\_\_\_

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

Birth Trauma (if known) \_\_\_\_\_

Method of Contraception (circle) 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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Painful periods                         | <input type="checkbox"/> Irregular cycles (early or late)                |
| <input type="checkbox"/> Dark, thick blood at beginning of cycle | <input type="checkbox"/> Dark, thick blood at end of cycle               |
| <input type="checkbox"/> Headache or migraine with period        | <input type="checkbox"/> Dizziness with period                           |
| <input type="checkbox"/> Bloating/water retention with period    | <input type="checkbox"/> Heaviness in pelvis with period                 |
| <input type="checkbox"/> PMS/depression with or before period    | <input type="checkbox"/> Excessive bleeding with period (> one pad/hour) |
| <input type="checkbox"/> Failure to ovulate                      | <input type="checkbox"/> Painful ovulation                               |
| <input type="checkbox"/> Varicose veins                          | <input type="checkbox"/> Tired, weak legs                                |
| <input type="checkbox"/> Numb legs and feet when standing        | <input type="checkbox"/> Sore heels when walking                         |
| <input type="checkbox"/> Low back ache                           | <input type="checkbox"/> Painful intercourse                             |
| <input type="checkbox"/> Constipation                            | <input type="checkbox"/> Endometriosis                                   |
| <input type="checkbox"/> Endometritis/uterine infections         | <input type="checkbox"/> Uterine polyps                                  |
| <input type="checkbox"/> Fibroids                                | <input type="checkbox"/> Vaginal discharge/Vaginitis                     |
| <input type="checkbox"/> Bladder Infections/incontinence         | <input type="checkbox"/> Chronic miscarriage                             |
| <input type="checkbox"/> Weak newborn infants                    | <input type="checkbox"/> Premature deliveries                            |
| <input type="checkbox"/> Incompetent cervix                      | <input type="checkbox"/> Spotting with pregnancy                         |
| <input type="checkbox"/> Pelvic inflammation                     | <input type="checkbox"/> Sexually transmitted infection                  |
| <input type="checkbox"/> Dry vagina                              | <input type="checkbox"/> Difficult menopause                             |
| <input type="checkbox"/> Cancer, especially of reproductive area | <input type="checkbox"/> Cysts, especially breast/ovarian                |
| <input type="checkbox"/> 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:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Hot flashes       | <input type="checkbox"/> Flooding                | <input type="checkbox"/> Anxiety             |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Disturbed sleep pattern | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Spotting          | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Mood swings         |
| <input type="checkbox"/> Decreased libido  | <input type="checkbox"/> Depression              | <input type="checkbox"/> Irritability        |
| <input type="checkbox"/> Insomnia          | <input type="checkbox"/> Irregular menses        | <input type="checkbox"/> Increased libido    |
| <input type="checkbox"/> Dry vagina        | <input type="checkbox"/> Memory Loss             |  |

**Additional Comments:**