Client Information and Informed Consent Sheet

The **Arvigo Techniques of Maya Abdominal Therapy**
Confidential Intake Form
In order to serve you better and make the most or your session,
please fill this form out PRIOR to attending your session. Thank you!

PLEASE PRINT

DATE: _____
Whom may we thank for referring you?_____

NAME_____DOB_____/_____/_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE (home)_____(work/cell)_____

EMAIL_____
(You will be added to the TaoMassage business list and receive periodic annoucements, promotions, etc)
❑ DO NOT ADD ME TO EMAIL LIST

Occupation?_____ Married?/Children?_____

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: _____

Client Initials: _____Case Study#_____Age_____Male_____Female_____

Date of Visit:_____Practitioner Name_____

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 /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:

	Past	Present		Past	Present
Headaches type:			Numbness in feet or legs when starting the day		
Asthma			Sore heels when walking		
Cold hand or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent colds			Fainting spells		
Seizures			Muscular tension: Location:		
Low back pain			Varicose Veins Location		
Skin disorders type:			Hemorrhoids		
Sciatica			Herniated/bulging discs		
Painful/swollen joints			Artificial/missing limbs		
Dentires/partials			Contact lenses		
			Cancer (past or current) type:		

FAMILY HISTORY

	Still Living?	Cause of Death/ag 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?_____Quantitiy_____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 _____

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 in each of these qualities:
Faith____Hope___Charity___Generosity____Sense of Humor___Fear_____Grief____Sense of Fun____
Other (describe briefly)_____
What hobbies/ activities provide you with pleasure and accomplishment_____
Describe your exercise routine (type, frequency)_____
What changes would you like to achieve in 6 months:_____
One Year:_____

FEMALE REPRODUCTIVE HISTORY

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 _____
Are you under the treatment for Infertility_____
Describe current treatment to date :_____
(IUI, IVF,etc)_____

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_____

	Past	Present		Past	Present
Painful periods			Irregular cycles Early Late		
Heaviness in Pelvis prior to menses			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	Complication	Miscarriages	Terminations
Number of Births			
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) _____
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_____

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

MALE REPRODUCTIVE HEALTH HISTORY

Please check the symptoms below that apply

	Past	Present		Past	Present
Painful Urination			Urinary Retention		
Urinary Incon tinence 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 Comments

FOR YOUR INFORMATION

The following sometimes occurs during massage, they are normal responses to relaxation/massage. Trust your body to express what it needs to: need to move or change position :: sighing, yawning, change in breathing :: stomach gurgling :: energy shifts emotional feelings and/or expression :: movement of intestinal gas :: falling asleep :: memories :: needing to urinate

Please read the following statement carefully, then sign below.

II understand fully that massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment I may have.Because a massage therapist must be made aware of any existing physical conditions, I have stated all known medical conditions and take it upon myself to keep my therapist updated on my physical health.

II understand and accept that I may experience bruising, stiffness and/or soreness following receiving services from TaoMassage.

II understand and have read the TaoMassage office policy and understand that payment is due at the time of treatment. I agree to give 24 hours notice of cancellation of appointment.If less than 24 hours given I agree to pay for the missed scheduled session.Cases of extreme emergency are considered exceptions.

II understand that any illicit or sexually aggressive remarks, advances or gestures made by me will result in the immediate termination of the session,and I will be liable for payment of the scheduled appointment.

I have carefully read and understand all of the above and I have answered all questions fully and accurately.

CLIENT SIGNATURE _____DATE_____