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			Artifical/Missing limbs		

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/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: