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The Arvigo Techniques of Maya Abdominal Therapy™
Confidential Intake Form

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

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 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)_____

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?No What type?_____

Medical History

Are you currently under the care of another health care provider(s)?No 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 ☐	Numbness in feet or legs when star	Past ☐	Present ☐
Asthma	☐	☐	Sore heels when walking	☐	☐
Cold Hands or feet	☐	☐	Anxiety	☐	☐
Swollen ankles	☐	☐	Depression	☐	☐
Sinus Conditions Frequent Colds	☐	☐	Sleep Disturbance	☐	☐
Seizures	☐	☐	Fainting Spells	☐	☐
Low Back Pain	☐	☐	Muscular Tension: Location:	☐	☐
Skin Disorders: Type	☐	☐	Varicose Veins Hemorrhoids Location	☐	☐
Sciatica	☐	☐	Herniated/Bulging Discs	☐	☐
Painful/Swollen Joints	☐	☐	Artifical/Missing limbs	☐	☐
High or Low Blood Pressure	☐	☐	Contact Lenses	☐	☐
Dentures/Partials	☐	☐	Cancer (past or current) Type	☐	☐

Family History

	Still Living?	**Cause and Age of Death**	**Major Health Issues**
Mother	No		
Father	No		
Siblings Living Deceased	9 9		
Maternal Grandmother	No		
Maternal Grandfather	No		
Paternal Grandfather	No		
Paternal Grandmother	No		

Gastroinstestinal Health History

Describe your typical:

Breakfast:_____

Lunch:_____

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?_____

Food Allergies?_No_Describe_____

How often are your bowel movements?_____Do your stools: sink_____float_____

Constipation?_____Blood in stool ?_No_Mucus in stool?_No_Pain when stooling?_No_

Diarrhea?_No_____Other?_____

Lifestyle, Emotional & Spiritual

What is your opinion of yourself?_____

Describe the most positive emotion you experience_____

When and Where do you experience this emotion?_____

Describe the most negative emotion you experience_____

When and Where do you experience this emotion?_____

Describe your Spiritual and/or Religious practice:_____

On a scale of 1 – 10 *(1 being the lesser, 10 the greater*) Please rate yourself in each of these qualities:

Faith_10_Hope_10_Charity_10_Generosity_10_ Sense of Humor_10_Fear_10_Grief_10_Sense of Fun_10_

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:_____

Do you use Tobacco?_No_Quantity_____/ppd Alcohol?_No_Quantitiy_____ounces/ day

Marijuana?_No_Quantity_____Other:_____ Have you been under treatment for substance use? No

Female Reproductive Health History

Method of Contraception (circle) Other pills patch diaphragm injection condoms IUD abstinence rhythm method

Fertility Awareness Other:_____Length of time using method_____Last Pap smear____Results _____

Are now or in the past experiencing Fertility Challenges? Yes☐ No☐ Describe your treatment :_____

(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? Yes☐ No☐ Are you Pregnant? Yes☐ No☐ Unsure☐

Painful Periods	Past ☐	Present ☐	Irregular cycles Early☐ Late☐	Past ☐	Present ☐
Heaviness in Pelvis prior to menses	☐	☐	Dark Thick Blood at: Beginning End Both	☐ ☐ ☐	☐ ☐ ☐
Excessive Bleeding Pads per Hour	☐	☐	Headache or Migraine with menses	☐	☐
Dizziness	☐	☐	Bloating	☐	☐
Water Retention	☐	☐	Ovulation: Painful Failure to Both	☐	☐
Endometriosis Location (if known)	☐	☐	Fibroids Location (if known)	☐	☐
Uterine or Cervical Polyps Cervical	☐	☐	Uterine Infection(s)	☐	☐
Vaginal Infection(s)	☐	☐	Cysts Location:	☐	☐
Bladder Infection(s)	☐	☐	Urinary Incontinence	☐	☐
Painful Intercourse	☐	☐	Vaginal Dryness	☐	☐
Episodes of Amenorrhea How long?	☐	☐			

Rate your interest in Sex: High☐ Moderate☐ Low☐ None☐

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced trauma? Yes☐ No☐ Describe_____

Did you undergo counseling for this_____

What was this like for you_____

Pregnancy History

Number of Pregnancies:_____Dates_____Miscarriage(s)_____Dates_____Termination(s)_____Dates:_____

Number of Births:_____ Dates:_____

Complications for any of the above, describe:_____

Premature Births?_____ Spotting During Pregnancy? _____Weak Newborns? _____Incompetent Cervix? _____

Describe your experience with:

Pregnancy:_____

Labor:_____

Birthing_____

Post Partum:_____

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

Cancer(type)_____Menstrual Problems _____ Other_____

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

Your Birth Trauma (if known) _____

Menopause

Age symptoms began:_____Are they getting worse☐better☐same☐

Are you on/ or ever been on hormone replacement therapy?No 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

Painful Urination	Past	Present	Urinary Retention	Past	Present
Urinary Incontinence 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 trauma: describe _____

Did you undergo counseling for this _____

What was this like for you _____

Additional Comments: