



## 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 \_\_\_\_\_

Female \_\_\_\_\_ Male \_\_\_\_\_ Other \_\_\_\_\_ Preferred Pronoun \_\_\_\_\_

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) \_\_\_\_\_ 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: \_\_\_\_\_

## For Administrative Use Only

Client Initials: \_\_\_\_\_ Case Study # \_\_\_\_\_ Age \_\_\_\_\_ Anatomy: 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 standing		
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			Artificial/Missing limbs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Cancer (past or current) Type		

Other (not mentioned above):

**Family History**

	Still Living?	Cause of Death/age 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? \_\_\_\_\_ Quantity \_\_\_\_\_ 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 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: \_\_\_\_\_  
Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method  
Fertility Awareness Other: \_\_\_\_\_ Length of time using method \_\_\_\_\_

## Reproductive Health History Female Anatomy

Last Pap smear \_\_\_\_\_ Results (if known) \_\_\_\_\_

Are you under the treatment for Infertility \_\_\_\_\_ Describe current treatment to date: \_\_\_\_\_

(IUI, IVF, etc.) \_\_\_\_\_

Gynecological Provider: \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**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 \_\_\_\_\_

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		
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:**

<b>Number of Pregnancies:</b>  <b>Number of Births:</b> <b>Dates:</b>	<b>Complications:</b>	<b>Miscarriages:</b>	<b>Terminations:</b>
<b>Premature Births:</b>	<b>Spotting during Pregnancy</b>	<b>Weak Newborns at Birth</b>	<b>Incompetent Cervix</b>

**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) \_\_\_\_\_**

**Other:**

**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 \_\_\_\_\_**

**Please feel free to share any additional information:**

**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			

**Reproductive Health History  
Male Anatomy**

Please check the symptoms below that apply

	Past	Present	Urinary Retention	Past	Present
Painful Urination			Difficult starting or holding urine stream		
Urinary Incontinence or Dribbling			Blood or pus in urine		
Weak or Interrupted Urine flow			Pelvic pressure		
Pain or Burning with Urination			Insatiable sex drive		
Nocturnal Urination How many times?			Pain or Discomfort Between scrotum and Testicles		
Pain in lower back, esp. After intercourse			Pain or Discomfort in Inner thighs: Left Right Both		
Pain or Discomfort in: Penis Testicles Rectum			Erection: Difficulty in Obtaining Maintaining Painful ejaculation		
Frequent Bladder or Kidney Infections When?					

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