Confidential Intake Form

Date of Initial Visit_____

Name:_____

Address_____

State_____Zip_____

Home Phone_____ Work_____

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 48 hours 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.
- As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations.
- 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_____

HIPPA

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, Angela Ferri to take notes about me, including health history/medical and/or personal information I choose to disclose to him/her. I understand that this information may 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 05/16/14

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(s)**_____

_____

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:

Condition	Past	Present	Condition	Past	Present
Headaches/type?			Spinal Problems		
Pins/Needles: arms/legs/hands/feet			Cold Hands or Feet		
Asthma			Anxiety		
Swollen Ankles			Depression		
Sinus Conditions			Frequent Colds		
Sleep Disturbance			Seizures		
Loss of Memory			Skin Disorders(type?)		
Varicose Veins (location?)			Hemorrhoids		
Sciatica			Muscular Tension (Location?)		
Painful/Swollen Joints			Herniated/Bulging Disks		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Artificial/Missing Limbs		
Fainting Spells			Loss of Smell or Taste.		

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

Relation	Still Living?	Cause/Age of Death	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

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 challenging 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:_____

_____

REPRODUCTIVE 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:_____

_____

Birthing:_____

_____

Post Partum:_____

_____

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

_____

Your Own Birth Experience (if known)

_____

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, time-period: last 6 months:

Condition	Past	Present	Condition	Past	Present
Painful periods			Irregular Cycles: early or late		
Dark Thick book at beginning of cycle			Dark thick blood at 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 (more than one pad an hour?)		
Failure to ovulate			Painful ovulation		
Varicose veins			Tired weak legs		
Numb legs/feet when standing			Sore heels when walking		
Low back ache			Painful intercourse		
Constipation			Endometriosis		
Endometritis/uterine infections			Uterine Polyps		
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_____

_____

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 currently:

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:	