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 _______________ e-mail address ________________

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 healthcare 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 that all practitioners obtain a signed release form from their client before taking any information. 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 her or his records.

I, (name) ____,

give my permission for my practitioner to take notes about any 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: ________________

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Client

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? ______________

Does it interfere with work? _______Sleep?_______ Recreation?_________

Have you had massage/bodywork before? ____________ What type? ______________________________________

Medical History

Are you currently under the care of another healthcare provider(s)? __________________

Reason(s) ____

____

Name(s) of practitioner(s) ____

Address ____

Phone ________________________________ e-mail ____

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:

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Page 2. Case Study Intake Form

Please review and check the following:

SYMPTOM/CONDITION	PAST	PRESENT	SYMPTOM/CONDITION	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 of tension		
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		

Family History

	Still Living?	**Cause and Age of Death**	**Major Health Issues**
Mother			
Father			
Siblings			
Maternal grandmother			
Maternal grandfather			
Paternal grandfather			
Paternal grandmother			

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Gastrointestinal 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? ___ Describe___

How often are your bowel movements? ___ Do your stools: sink ___ float ___

Constipation? ___ Blood in stool? ___ Mucus in stool? ___ Pain when stooling?___

Diarrhea?___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 to 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 ___

What hobbies/activities provide you with pleasure and sense of accomplishment? ___

___

Describe your exercise routine (type, frequency) ___

What changes would you like to achieve in 6 months? ___

In one year? ___

Do you use tobacco? ___ Quantity ___ /per day Alcohol?___ Quantitiy ___ ounces/day

Marijuana? ___ Quantity ___ Other:___

Have you been under treatment for substance use?

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Female Reproductive History

Method of contraception (circle one): pills patch diaphragm injection condoms IUD abstinence rhythm method fertility awareness other: ____________

Length of time using method ________ Last Pap smear ____Results _____

Are you now experiencing fertility challenges? Yes ___ No ___ Describe your treatment: ______________

(IUI, IVF, etc.) ____

Have you in the past experienced fertility challenges? Yes____ No ____

Describe your treatment: ____

(IUI, IVF, etc.) ____

History of Sexually Transmitted Disease Yes ___ No ___ If yes, describe: ____________________

Menstrual History

Review and check as indicated:

Age at first 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 ____

SYMPTOM/CONDITION	PAST	PRESENT	SYMPTOM/CONDITION	PAST	PRESENT
Painful Periods			Irregular cycles (early? late?)		
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?					

Rate your interest in sex: high ______ moderate ______ low ______ none ______

Do you have or have you ever had difficulty experiencing orgasms? ____________________

Have you experienced trauma? Yes ___ No ____ Describe ______________________________

Did you undergo counseling for this? ______________________________________

What was this like for you? ____

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Pregnancy History

Number of Pregnancies ___ Date(s) ____ Miscarriage(s) ___ Dates ____ Termination(s) ___ Dates _____

Number of Births ______ Date(s) ______________________________

Complications for any of the above? Describe: ______________________________

Premature births? ____ Spotting during pregnancy? ____ Weak newborns? ___ Incompetent cervix? ___

Describe your experience with

Pregnancy ______________________________

Labor ______________________________

Birthing ______________________________

Postpartum ______________________________

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) ______________________________

Menopause

Age symptoms began _______ Are they getting worse? _______ Better? _______ Same?_______

Are you taking or have you ever taken hormone replacement therapy? ____ If so, for how long?________

Name and dosage ______________________________

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:

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Male Reproductive Health History

Please check the symptoms below that apply:

SYMPTOM/CONDITION	PAST	PRESENT	SYMPTOM/CONDITION	PAST	PRESENT
Painful urination			Urinary retention		
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, especially 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 kno____________________________ 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:

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NOTES:

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