# 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)_____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.

ClientSignature: _____ 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?_____ 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

**Page 2.** **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 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?_____Quantitiy_____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 _____:_____

## 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 in each of these qualities:

Faith_____Hope____Charity____Generosity_____ Sense of Humor_____Fear_____Grief_____Sense of Fun_____

Other (describe briefly)_____

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:_____

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## Female Reproductive Health History

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method Fertility Awareness Other:_____Length of time using method_____Last Pap smear____Results _____

Are you under the treatment for Infertility_____Describe current treatment to date :_____

(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_____Possibility of Pregnancy_____

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

## Pregnancy History

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

### 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) _____

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_____

## 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 | | | |

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 rape_____trauma_____incest_____If so,-when_____**

**Did you undergo counseling for this_____**

**What was this like for you_____**

## Additional Comments