



The *Arvigo*
Techniques of Maya
Abdominal Therapy®

Confidential Intake Form

Date of Initial Visit: _____

Name: _____

Address: _____

Province: _____ Postal Code: _____ Phone: _____

Email: _____

Date of Birth: _____ Age: _____

☐ Female

☐ Male

☐ Other

Preferred Pronoun: _____

Occupation: _____ Marital 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: _____

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? _____ ☐ Interferes 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: _____

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	☐	☐	Numbness in feet or legs	☐	☐
Type:			when standing		
Asthma	☐	☐	Sore heels when walking	☐	☐
Cold hands or feet	☐	☐	Depression	☐	☐
Swollen ankles	☐	☐	Anxiety	☐	☐
Sinus conditions or	☐	☐	Sleep disturbances	☐	☐
frequent colds			Fainting spells	☐	☐
Seizures	☐	☐	Muscular tension	☐	☐
Low back pain	☐	☐	Location:		
Skin disorders	☐	☐	Varicose Veins	☐	☐
Type:			Hemorrhoids	☐	☐
Sciatica	☐	☐	Location:		
Painful/swollen joints	☐	☐	Herniated/bulging discs	☐	☐
Dentures/partials	☐	☐	Artificial/missing limbs	☐	☐
			Contact lenses	☐	☐
			Cancer	☐	☐
			Type:		

Other:

Family History

	Major health issues	Cause of death/at what age
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: _____

Do you use tobacco? _____ Quantity: _____ 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 and 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):

Birth control pill
Patch
Diaphragm
Injection
fertility awareness

Condoms
IUD
Abstinence
Rhythm method
Other: _____

Length of time using method: _____

Reproductive Health History - Female Anatomy

Last Pap smear: _____ Results (if known): _____

Are you under treatment for infertility? _____ Describe current treatment to date: (IUI, IVF, etc.): _____

Gynecological Provider: _____

Menstrual history review and check as indicated:

Age of Menses: _____ What was this like for you? _____

Last Menstrual Period: _____ Length of Menses: _____ Length of Cycle: _____

Are you trying to conceive? _____ Possibility of Pregnancy? _____

	Past	Present		Past	Present
Heaviness in pelvis prior to menses	☐	☐	Irregular cycles (early/late)	☐	☐
Painful periods	☐	☐	Bloating	☐	☐
Excessive bleeding	☐	☐	Vaginal dryness	☐	☐
Dizziness	☐	☐	Uterine infection	☐	☐
Uterine or cervical polyps	☐	☐	Urinary incontinence	☐	☐
Bladder infections	☐	☐	Headache or migraine with menses	☐	☐
Vaginal infections	☐	☐	Uterine fibroids	☐	☐
Episodes of amenorrhea (how long)	☐	☐	Ovulation: painful or failure to	☐	☐
Painful intercourse	☐	☐	Dark, thick blood	☐	☐
Endometriosis	☐	☐	Cysts (location):	☐	☐
Painful/swollen joints	☐	☐			

Pregnancy History:

Number of pregnancies: Number of births: Dates:	Complications:	Miscarriages:	Terminations:
Premature births:	Spotting during Pregnancy:	Weak newborns at birth:	Incompetent cervix:

Briefly 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): _____

Other: _____

Rate your interest in sex: High _____ Moderate _____ Low _____ None _____

Do you have or ever had difficulty experiencing orgasms? _____

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	☐

Additional Information: