

# 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) \_\_\_\_\_

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: \_\_\_\_\_

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:

**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			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			

**Gastrointestinal Health 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 – 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 accomplishment \_\_\_\_\_

Describe your exercise routine (type, frequency) \_\_\_\_\_

What changes would you like to achieve in 6 months: \_\_\_\_\_

One Year: \_\_\_\_\_

Do you use Tobacco? \_\_\_\_\_ Quantity \_\_\_\_\_ /ppd Alcohol? \_\_\_\_\_ Quantitiy \_\_\_\_\_ ounces/ day

Marijuana? \_\_\_\_\_ Quantity \_\_\_\_\_ Other: \_\_\_\_\_ Have you been under treatment for substance use?

**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 now or in the past experiencing Fertility Challenges? Yes \_\_\_ No \_\_\_ Describe your treatment : \_\_\_\_\_  
 (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? Yes \_\_\_ No \_\_\_ Are you Pregnant? Yes \_\_\_ No \_\_\_ Unsure \_\_\_

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?					

Rate your interest in Sex: High \_\_\_\_\_ Moderate \_\_\_\_\_ Low \_\_\_\_\_ None \_\_\_\_\_

Do you have or ever had difficulty experiencing orgasms \_\_\_\_\_

Have you experienced trauma? Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_

Did you undergo counseling for this \_\_\_\_\_

What was this like for you \_\_\_\_\_

**Pregnancy History**

Number of Pregnancies: \_\_\_\_\_ Dates \_\_\_\_\_ Miscarriage(s) \_\_\_\_\_ Dates \_\_\_\_\_ Termination(s) \_\_\_\_\_ Dates: \_\_\_\_\_

Number of Births: \_\_\_\_\_ Dates: \_\_\_\_\_

Complications for any of the above, describe: \_\_\_\_\_

Premature Births? \_\_\_\_\_ Spotting During Pregnancy? \_\_\_\_\_ Weak Newborns? \_\_\_\_\_ Incompetent Cervix? \_\_\_\_\_

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

**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:

<b>Male Reproductive Health History</b>
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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 trauma: describe \_\_\_\_\_

Did you undergo counseling for this \_\_\_\_\_

What was this like for you \_\_\_\_\_

Additional Comments: