

Confidential Intake Form

Date of Initial Visit _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Email: _____

Occupation: _____ Hours Worked Per Week: _____ Marital/Relationship Status: _____

Referred by: _____

Client Confidentiality Form

I understand that payment is due at the time of treatment unless arrangements have been made otherwise.

I agree to give at least 24 business hours notice of cancellation of an appointment. I also understand I will be billed \$50 for a missed appointment or one not cancelled before 24hrs prior to my appointment.

I understand that my appointment begins at the time scheduled. If I arrive late, my appointment will be shortened and I will be charged for the full visit.

I understand the treatment 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 (unless specified under his/her professional scope of practice)

As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice)

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: _____

Client Name Printed: _____

Please Advise Us if You Are Ill Today. We Will Need to Reschedule Your Massage.

Massage Information

First Professional Massage?: Yes No How Frequently Do You Receive Massage?: _____

What Types/Modalities of Massage Have you Received?: _____

Medical Information

List major accidents/injuries, hospitalizations, and surgeries...

Are you currently under the care of a physician? Please list all prescriptions, supplements, or herbs you taking and reason for taking them.

Medical History

Musculoskeletal

- Arthritis
- Chronic Headaches
- Chronic Pain in:
 - Back
 - Upper-back
 - Mid-back
 - Lower-back
 - Neck
- Fibromyalgia
- Osteoporosis
- Tendonitis
- Whiplash

Respiratory

- Asthma
- Breathing Problems

Circulatory

- Heart Problems
- Hemophilia
- Low/High Blood Pressure
- Stroke
- Varicose Veins

Skin

- Athlete's Foot
- Eczema/Dermatitis
- Psoriasis
- Easily Irritated Skin

Nervous System

- Dizziness
- Multiple Sclerosis
- Seizures/Epilepsy

Other

- Anxiety/Panic Attacks
- High Stress
- PMS/Menopause Difficulties
- Poor Sleep/Insomnia
- Postoperative:
- Pregnancy/ Weeks:
 - Due Date:
 - Complications/Concerns

Any issues not listed above? Please Describe: _____

Exercise

Activities: _____ Number of times/days per week: _____

Please, also, fill this form out if you are receiving a Maya Therapy Session

Reason For Visit

Primary reason for visit: _____
 When did you first notice it? _____ What brought it on? _____
 Any stressors occurring at the time _____
 What activities provide relief? _____
 What makes it worse? _____
 Is this condition getting worse? _____ Interfere with Work _____ Sleep _____ Recreation _____

Medical History

Are you currently under the care of another health care provider(s) _____ Reason (s) _____
 Name(s) of Practitioner: _____ Phone: _____
 Current Medications and/or Supplements/Remedies: _____

 Allergies, specify allergen and reaction: _____
 Surgical History (year and type) and Recent Procedures: _____

 Hospitalizations: _____
 Accidents or Traumas: _____
 Falls/Injuries to Sacrum/head/tailbone (describe): _____
 Other: _____

Please Review and Check the Following:

Headaches	Past	Present	Pins & Needles in arms, legs, hands or feet	Past	Present	
Asthma	Past	Present	Spinal Problems	Past	Present	
Cold Hands or Feet	Past	Present	Anxiety	Past	Present	
Swollen ankles	Past	Present	Depression	Past	Present	
Sinus Conditions, Frequent Colds	Past	Present	Sleep Disturbance	Past	Present	
Seizures	Past	Present	Fainting Spells	Past	Present	
High or Low Blood Pressure	Past	Present	Loss of Memory	Past	Present	
Skin Disorders:	Past	Present	Varicose Veins	Hemorrhoids	Past	Present
Sciatica	Past	Present	Muscular Tension:		Past	Present
Painful/Swollen Joints	Past	Present	Herniated/Bulging Discs		Past	Present

Digestion & Elimination

Water Intake(glasses/day) _____ Caffeine _____
 What is the worst item in your diet: _____ What foods are your weakness: _____
 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 present? _____ Mucus present? _____ Painful? _____

Male Reproductive Health History (Men Only)

Headaches: Migraine ___ Tension ___ Cluster ___ Low Back Pain ___ Sore Heals ___ Varicose Veins ___ Numbness in Legs/Feet ___
 Family History of Cancer: _____ Type: _____ Relationship: _____
 History of STD: _____ When: _____ Type: _____
 Rate You Interest in Sex: High Moderate Low None Difficulty experiencing Orgasms: _____
 Have you experienced a history of Rape Trauma Incest If so, when: _____
 Did you undergo counseling for this: _____

Urinary Symptoms

Circles Those Applicable: Painful Urination Bladder/Kidney Infections Frequent Urination Nocturnal Urination

When did you first notice these symptoms: _____ Are they getting better or worse: _____

Erectile Function

Difficulty Obtaining an Erection: _____ Difficulty maintaining an Erection: _____ Painful Ejaculation: _____

Is there a history of back injury/trauma: _____ Describe: _____

Current Medications or Supplements: _____

Female Reproductive Health History (Women Only)

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: _____ Complications: _____

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): _____

Birth Trauma (if known): _____

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 (if known): _____

Date of Last Menstrual period: _____ Length of Menses: _____ Are you Pregnant: _____ Trying to Conceive: _____

Episodes of Amenorrhea: _____ When: _____ For how long: _____

Are you under the treatment for Infertility: _____ Describe current treatment to date (IUI, IVF, etc): _____

Gynecological Provider: _____ Clinic: _____

Phone: _____

Rate your interest in Sex: High: ___ Moderate: ___ Low: ___ None: ___ Do you 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: _____

Please Check as Appropriate:

Painful Periods	Bloating/Water Retention with period	Low back ache
Dark, thick blood at beginning of cycle	PMS/Depression with or before period	Pelvic Inflammation
Headache or Migraine with period	Failure to Ovulate	Painful intercourse
Constipation	Bladder Infections/Incontinence	Sexually Transmitted Disease
Vaginal Discharge/Vaginitis	Cancer esp of reproductive area	Difficult menopause
Fibroids	Incompetent cervix	Cysts esp breast/ovarian
Irregular Cycles (early or late)	Heaviness in pelvis with period	Spotting with pregnancy
Dark thick blood at the end of cycle	Excessive Bleeding (> one pad/hour)	Chronic Miscarriage
Dizziness with period	Painful Ovulation	Premature deliveries
Endometriosis	Uterine Polyps	
Other:		

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis PMS

Cancer(type): _____ Menstrual Problems: _____