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Confidential Intake Form

Date of Initial Visit_______________

Name:____________________Address______________________ City______________ State_____ Zip_________

Home Phone____________________ Work Phone______________________ Cell_________________________

Email________________________ Date of Birth_________________ Age__________

Occupation_____________________________________ Marital/Relationship Status_______________________

Referred by____________________________________

Client Confidentiality Release Form

I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
I agree to give at least 24hours notice of cancellation of appointment.
Cases of extreme emergency are considered exceptions to this cancellation policy.
I understand the treatment here 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____________________

Therapist/Practitioner signature:____Date_____________________

HIPAA regulations require all practitioners should have a signed release form from their client *before* taking any notes about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Practitioners should have this form signed before taking any notes. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance.

Failure to comply with these confidentiality regulations could result in penalties.

I, (name)____give my permission, for my therapist/practitioner, _***Tiffany Ueltschi, LMT***_ to take notes about me, 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 will be shared with the Arvigo Institute, LLC .

I understand that this information will anonymously be used for the Arvigo Institute, LLC . for statistical purposes only, and that my practitioner may use this information to provide me with a summary for my own personal use.

Signature: ____ Date: ______________________

Therapist/Practitioner signature:_____________________________________Date___________________

Revised on 04/22/08

Practitioner: DO NOT send this page with your case study report – for your records ONLY

For Official Use
Client Initials: _______________________________Case Study #_________
Date of Visit:_______________________________Age________Male_______Female______

Reason For Visit

Primary reason for visit: ____

When did you 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/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:

Headaches Type:	Past	Present	Pins and 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
Loss of smell or Taste	Past	Present	Loss of Memory	Past	Present
Skin Disorders: Type:	Past	Present	Hemorrhoids Varicose Veins Location	Past	Present
Sciatica	Past	Present	Muscular Tension: Location:	Past	Present
Painful/Swollen Joints	Past	Present	Herniated/Bulging Discs	Past	Present
High or Low Blood Pressure	Past	Present	Contact Lenses	Past	Present
Dentures/Partials	Past	Present	Artificial/Missing Limbs	Past	Present

Other (not mentioned above): ______________________________

Do you use Tobacco? _______ Quantity _____/ppd Alcohol? _____ Quantity _______ Ounces/day _______

Marijuana? _________ Quantity __________________ Other: ______________________________

Have you been under treatment for substance use? ______________________________

Family History

	Still Living?	Cause of Death/age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Digestion & Elimination

Typical Breakfast: ______________________________

Typical Lunch: ______________________________

Typical 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? __________

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

Constipation? ______ Blood in stool ? ______ Mucus in stool? ______ Pain when stooling? ________

Other concerns: ______________________________

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:

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: ______________________________

____

____

Male Reproductive Health History (Men Only)

Please Check and Describe Those Symptoms as Applicable

Headaches: Migraine _______ Tension ________ Cluster _______ Low Back Pain _______ Sore Heals _________

Varicose Veins ________ Location ___________________________________Numbness in Legs/Feet __________

Family History of Prostate Disease: _________ Type: ______________ Relationship: ___________________________

Family History of Cancer: _________Type: _______________________ Relationship: ___________________________

History of STD: ____________ When: _____________ Type: ____

Rate You Interest in Sex: High Moderate Low None

Do you have 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 is like for you: ____

Urinary Symptoms

Circles Those Applicable

Painful Urination
Bladder/Kidney Infections
Frequent Urination
Nocturnal Urination/Frequency
Changes in Urinary Stream (describe flow, stream, strength of stream) ________________________________

When did you first notice these symptoms: ____

Are they getting better or worse: ___________ Describe: ____

Erectile Function

Describe As Indicated

Difficulty Obtaining an Erection: ____________________ Difficulty maintaining an Erection: __________________

Painful Ejaculation: ______________________

Is there a history of back injury/trauma: ________ Describe: ____

When did you first notice these symptoms: ____

Are they getting better or worse: ___________ Describe: ____

Current Medications or Supplements: ____

____

____

Results of PSA (prostate specific antigen) Test if known: ______________ Date done: _________________________

Results of Sperm Count (if applicable and known): __________________ Date done: _________________________

Additional Comments: ____

____

____

____

Female Reproductive Health History (Female 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: ____

Address: ____ Phone: _____________________

Rate your interest in Sex: High: ___________ Moderate: _________ Low: __________ None: ______________

Do you have 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	Irregular Cycles (early or late)
Dark, thick blood at beginning of cycle	Dark thick blood at the end of cycle
Headache or Migraine with period	Dizziness with period
Bloating/Water Retention with period	Heaviness in pelvis with period
PMS/Depression with or before period	Excessive Bleeding (> one pad/hour)
Failure to Ovulate	Painful Ovulation
Varicose Veins	Tired weak legs
Numb legs and feet when standing	Sore heels when walking
Low back ache	Painful intercourse
Constipation	Endometriosis
Uterine Infections	Uterine Polyps
Fibroids	Vaginal Discharge/Vaginitis
Bladder Infections/Incontinence	Chronic Miscarriage
Weak newborn infants	Premature deliveries
Incompetent cervix	Spotting with pregnancy
Pelvic Inflammation	Sexually Transmitted disease
Dry Vagina	Difficult menopause
Cancer esp. of reproductive area	Cysts esp. breast/ovarian
Other:	

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

Cancer(type): ______________________ Menstrual Problems: ______________________

Other: ____

____

____

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 Comments: ____

____

____