

The Arvigo Techniques of Maya Abdominal Therapy™  
**Confidential Intake Form**

Name:

Address:

Postcode

Telephone number – Evening:

Day:

E-mail:

Mobile:

DOB:

Age:

Occupation

Marital status:

How did you hear about Arvigo Therapy and Touching Well?

Client declaration: Please sign that:

- I consent to having Arvigo Techniques of Maya Abdominal Therapy™
- I understand that the treatment is no substitute for medical advice
- I will let the practitioner know immediately if I feel uncomfortable at any time during the session
- I will give complete and accurate medical and other relevant information and I will inform the practitioner of any changes.
- I understand that if I cancel a session less than 48 hours prior to the start of the session I am liable for the full fee, unless negotiated otherwise.
- I understand that there is no guarantee that the outcome will be met

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

This form devised by Rosita Arvigo herself. Please print it out, complete and bring to the session.

Please complete only what you feel comfortable sharing. You can scribble all over, add notes, etc

I look forward to seeing you.

## Confidential Intake Form

### 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 /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 Type:			Numbness in feet or legs when standing		
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 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? \_\_\_\_\_

Diarrhoea? \_\_\_\_\_ 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 Humour \_\_\_\_\_ 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? \_\_\_\_\_ Quantity \_\_\_\_\_ ounces/ day

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

## Male Reproductive Health History

Please check the symptoms below that apply

	Past	Present		Past	Present
Painful Urination			Urinary Retention		
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: