The Arvigo Techniques of Maya Abdominal Therapy™

Confidential Intake Form

Name:

Address: Postcode

Telephone number – Evening: Day:

E–mail: Mobile:

DOB: Age:

Occupation Mariatal 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.

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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		Artifical/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?______Quantitiy______ounces/ day

Marijuana?_______Quantity______Other:_________________ Have you been under treatment for substance use?

Female Reproductive Heath 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____

	Past Present		Past Present
Painful Periods		Irregular cycles Early Late	
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 counselling 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:____

Labour:____

Birthing____

Post Partum:____

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