



MAYAN ABDOMINAL MASSAGE Confidential Information Form for Women

Date of initial visit:

Name:

Address:

State:

ZIP:

Home phone:

Work phone:

Cell phone:

e-mail:

Date of birth:

Occupation:

Marital/Relationship status:

Referred by:

Client confirmation of understanding

- I understand that payment is due at the time of treatment unless other arrangements have been made.
- I agree to give at least 24 hours' notice if canceling an appointment (excepting emergencies).
- I understand that treatment here is not a replacement for medical care.
- I understand that the therapist/practitioner does not diagnose medical illness, disease or any other physical or mental conditions (unless specified under her/his professional scope of practice).
- As such, the therapist/practitioner does not prescribe pharmaceuticals, nor does she/he perform spinal manipulations (unless specified under her/his professional scope of practice)
- I understand that the treatment is not a substitute for medical procedures 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 that all practitioners obtain a signed release form from clients *before* taking notes about them. Upon request, clients receive a copy of the form they signed. The practitioner maintains a copy for her/his records.

The practitioner agrees to keep clients' medical and personal information, obtained during the course of her/his work, in strict confidence. Failure to comply with this confidentiality regulation could result in penalties.

I, (client's name)

of (address)

give my permission for my therapist/practitioner to take notes about me, including my health history and personal information that I choose to disclose. I understand that this information may be used for practitioner certification and will be shared anonymously with the Arvigo Institute, LLC for statistical purposes only. I understand that my practitioner may use this information to provide me with a summary for my own use.

Signature:

Date:

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

Client Initials:	Date of visit:	Case study #
Practitioner name:		Age:

Reason for Visit

Primary reason:

Other reason(s):

When did you first notice the problem?

What triggered it?

Describe any stressors occurring at the time:

What activities provide relief?

What makes it worse?

Is this condition getting worse?

Interferes 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(s):

Address:

Phone:

Current medications, supplements, remedies:

Allergies – specify allergen and reaction:

Surgical history (year and type) and/or recent procedures:

Hospitalizations:

Accidents or traumas:

Falls/injuries to head and tailbone (describe):

Other:

Review of symptoms

Please check any of the following you have experienced:

Headaches Type:	Past	Present	“Pins and needles” feeling in arms, legs, hands or feet	Past	Present
Asthma			Spinal problems		
Cold hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus conditions			Sleep disturbance		
Frequent colds					
Seizures			Fainting spells		
Loss of smell or taste			Loss of memory		
Skin disorders			Varicose veins, hemorrhoids		
Sciatica			Muscle tension		
Painful/swollen joints Location:			Herniated/bulging vertebral discs		
High or low blood pressure			Contact lenses		
Dentures/partials			Artificial/missing limbs Specify:		

Other (not mentioned above)

Do you use tobacco? packs/day Alcohol? ounces/ day
 Marijuana? Quantity Other: Have you had treatment for substance use?

Family history

	Still living	Cause of death	Age	Major health issues
Mother				
Father				
Siblings				
Maternal grandmother				
Maternal grandfather				
Paternal grandmother				
Paternal grandfather				

Other:

Digestive health

Typical breakfast:

Typical lunch:

Typical dinner:

Snacks:

Water intake (glasses/day):

Caffeine:

Worst item in your diet?

What foods are your weakness?

Are you subject to binge eating?

What foods?

Do you experience bloating/gas/belching after eating?

What foods trigger this?

How frequent are your bowel movements?

Do your stools: sink

float

Constipation?

Blood in stool?

Mucus in stool?

Pain when stooling?

Other concerns:

Emotional and spiritual health

What is your opinion of yourself?

Please describe the most negative emotion you experience:

When do you feel this emotion?

Do you have a spiritual practice? If so, please describe:

On a scale of 1 to 10 (1 lowest, 10 highest), please rate yourself regarding:

Faith

Hope

Charity

Generosity

Sense of humor

Sense of fun

Fear

Grief

Other (describe briefly)

What activities provide you with a sense of pleasure and/or accomplishment?

Describe your exercise routine (type, frequency)

What life changes would you like to achieve in 6 months?

One year?

Female Reproductive Health History

When did you begin your menses?

What was this like for you?

How many pregnancies have you had?

How many deliveries?

Dates

Termination(s) When

Miscarriage(s) When

Complications?

What was your experience of pregnancy?

Labor?

Delivery?

Post partum?

Medications your mother took when she was pregnant with you:

Birth trauma, if known:

Mother's family history of (*circle*): Infertility Fibroids Endometriosis Premenopausal syndrome Menopause

Cancer (type): Menstrual problems:

Other:

Method of contraception (*circle*): Pill Patch Diaphragm Injection Condoms IUD Abstinence Rhythm method

Fertility awareness Other: How long was method used?

Last Pap smear: Results:

Date of last menstrual period: Length of periods Are you pregnant? Trying to conceive?

Have your periods ever stopped? When? For how long?

Please check as appropriate:

Painful periods	Irregular cycles (early or late)
Dark, thick blood at beginning of cycle	Dark thick blood at end of cycle
Headache/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 or tampon/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
Endometritis/Uterine infection	Uterine polyps
Fibroids	Vaginal discharge/vaginitis/
Bladder infection/incontinence	Chronic miscarriage
Weak newborn infants	Premature deliveries
Incompetent cervix	Spotting with pregnancy
Pelvic Inflammation	Sexually transmitted disease
Dry vagina	Difficult menopause
Cancer, especially of reproductive area	Cysts, especially breast/ovarian
Other:	

Are you under the treatment for infertility? Describe:

Gynecologist: Address: Phone:

Is your interest in sex: High Moderate Low None

Do you have or ever had difficulty experiencing orgasm?

Have you experienced a history of rape? Sexual trauma? Incest? If so, when?

Did you receive counseling? Was counseling beneficial?

Menopause (Check the 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			

Age symptoms began: Are they getting worse? Better? Same?

Are you taking/have you ever taken hormone replacement therapy? If so, how long?

HRT name and dosage:

Reason for stopping:

Mother's age at menopause: Concerns/Experience:

Additional comments: