

Confidential Intake Form

Date of Initial Visit _____

Name: _____

Address _____

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 other wise.

I agree to give at least 24hourse 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) _____ address _____

give my permission, for my therapist/practitioner, _____ 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: _____

Revised on 04/22/08

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 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 /orSupplements/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			Spinal Problems		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Loss of smell or Taste			Loss of Memory		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Muscular Tension: Location:		
Painful/Swollen Joints			Herniated/Bulging Discs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Artificial/Missing limbs		

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 Grandmother			

Other:

Digestion and 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

Check and Describe those symptoms as applicable

Headaches: Migraine_____Tension_____Cluster_____Low back pain_____Sore heels_____

Varicose Veins _____ Location_____

Numbness in legs/feet _____

Family History of Prostate Disease: _____Type_____Relationship_____

Family History of Cancer _____Type_____Relationship_____

History of sexually transmitted disease _____When_____Type_____

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 _____

Urinary Symptoms (circle 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: