Amazing Births
Guidance & Support for Pregnancy . . . Birth & Beyond

## CONFIDENTIAL CLIENT INTAKE FORM

Name:_____Date of Initial Visit:_____

Address:_____State_____Zip_____

Home Phone:_____Work Phone:_____email:_____

Date of Birth:_____Age:_____Occupation:_____

Marital status:_____Referred by:_____

Have you had massage/bodywork before?_____ What type?_____

### REASON FOR VISIT

What is your primary concern?_____

What are other areas of concern?_____

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_____

Describe your exercise routine (type, frequency)_____

### FAMILY HISTORY

| | Alive? | Age/Cause of Death | Major Health Issues |
|---|---|---|---|
| Mother: | | | |
| Father: | | | |
| Siblings: | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |

Family History of Abuse_____circle if applicable : physical emotional sexual spiritual

Family History of Substance Abuse_____Suicide_____ Other Trauma_____

**DIGESTION & ELIMINATION**

Typical Breakfast:_____

Typical Lunch:_____

Typical Dinner:_____

Snacks:_____Water Intake(glasses/day)_____Caffeine_____

What is the worse thing on 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_____

## *Bladder*

Do you experience any of the following:

Loss of urine when coughing, sneezing, or laughing? Yes No

Frequent urination? (circle) Yes No

Need to urinate with little warning? (circle) Yes No

Difficulty passing urine? (circle) Yes No

Frequent bladder infections? (circle) Yes No

Frequency of nighttime urination:(circle) 0–1 2 or more Volume: Small Medium Large

Frequency of daytime urination: (circle) 8 or less 9–15 >16 Volume: Small Medium Large

Do you still feel full after urination? (circle) Yes No

## *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 ( 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_____

What changes would you like to achieve in 6 months: _____One Year:_____

## *Sexual and Physical Abuse History*

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted. Yes No No answer

Have you experienced a history of rape_____ trauma _____incest __If so,-when_____

Did you undergo counseling for this_____

What was this like for you_____

| | As a child (13 years and younger) | | As an adult (14 years and over) | |
|---|---|---|---|---|
| Circle an answer for both as a child and as an adult. | | | | |
| 1a. Has anyone ever exposed the sex organs of their body to you when you did not want it? | Yes | No | Yes | No |
| 1b. Has anyone ever threatened to have sex with you when you did not want it? | Yes | No | Yes | No |
| 1c. Has anyone ever touched the sex organs of your body when you did not want this? | Yes | No | Yes | No |
| 1d. Has anyone ever made you touch the sex organs of their body when you did not want this? | Yes | No | Yes | No |
| 1e. Has anyone ever forced you to have sex when you did not want this? | Yes | No | Yes | No |
| 1f. Have you had any other unwanted sexual experiences not mentioned above? If yes, please specify:_____ | Yes | No | Yes | No |

2. When you were a child (13 or younger), did an older person do the following?

a. Hit, kick, or beat you? Never Seldom Occasionally Often

b. Seriously threaten your life? Never Seldom Occasionally Often

3 Now that you are an adult (14 or older), has any other adult done the following:

a. Hit, kick, or beat you? Never Seldom Occasionally Often

b. Seriously threaten your life? Never Seldom Occasionally Often

*Leserman, J., Drossman, D., Li, Z: The Reliability and Validity of a Sexual and Physical Abuse History Questionnaire in Female Patients with Gastrointestinal Disorders. Behavioral Medicine 21:141–148, 1995*

## *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:_____

Allergies: specify allergen and reaction:_____

Supplements/Remedies_____

Do you use Tobacco?_____ Quantity_____/ppd Alcohol? _____Quantitiy _____ounces/ day

Marijuana?_____Quantity_____Other:_____
Have you been under treatment for substance use?

If so, describe:_____

Surgical History (year and type)_____

_____

Recent Procedures:_____

Hospitalizations _____

Accidents or Traumas_____

_____

Falls/Injuries to Sacrum/head/tailbone (describe)_____

Birth Trauma if known _____

*Circle* any of the following you are *currently* experiencing
Underline and of the following you have experienced in the past

Headaches (migraine, tension, cluster) Ringing in Ears Pins and needles in arms, legs, hands or feet

Asthma Cold Hands or Feet Swollen ankles Sinus Conditions Seizures

Loss of Smell or Taste Skin Disorders: Acne, Fungus, Psoriasis Other:_____

Sciatica Painful Joints Swollen Joints Spinal Problems Anxiety Fatigue

Trouble Sleeping Fainting Spells Loss of Memory Depression

Muscular Tightness: (location) _____ Varicose Veins (location)_____

Herniated or Bulging disc: (location)_____ High or Low Blood Pressure

Contact lenses Dentures Artificial /Missing limbs Frequent Colds/ Upper Respiratory conditions

## FEMALE ~ REPRODUCTIVE HEALTH HISTORY

Age of Menarche(first period)_____What was this like for you?_____

How many Pregnancies have you had? _____Number of Deliveries_____Dates_____

Termination(s)_____When_____

Miscarriage(s)?_____When_____

Any complications during pregnancy, labor, delivery, or post partum period?(circle)

4º Episiotomy C-section Post-partum hemorrhaging Vaginal lacerations Forceps Medication for bleeding

Other:
Complications_____

What was your experience of Pregnancy? _____

Labor?_____

Delivery?_____

Post Partum?_____

Medications your mother took when she was pregnant with you (if any)_____

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

Recurrent Urinary Tract Infections Chronic pelvic pain Cancer(type)_____

Menstrual Problems Menopause PMS

Method of Contraception: (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method Other:_____

Length of time on synthetic contraception (Pill, Patch or Injection):_____

Last Pap smear_____ Results ( if known)_____

Date of Last Menstrual period_____ Length of Menses_____

Episodes of Amenorrhea (when you did not bleed)_____When_____ For how long_____

**Please circle as appropriate:**

Painful periods Irregular (late or early)

Dark Thick Blood at Beginning or End of Cycle Dizziness with period

Headache or Migraine with period Excessive Bleeding (> one pad/hour)

PMS/Depression with or before period Failure to Ovulate

Painful Ovulation Bloating/water retention with period

Heaviness or pressure in lower pelvis with period

**Other Symptoms** (Circle and Describe as indicated)

Varicose veins of leg Tired weak legs Numb legs and feet when standing still Sore heels when walking

Low back ache Painful intercourse Constipation Endometriosis

Endometritis Uterine Polyps Fibroids (Size and Location if known)_____

Uterine infections Frequent urination Bladder infections Vaginal discharge (describe)

Vaginitis Vaginal Yeast infections Chronic miscarriages Premature deliveries

Weak newborn infants Difficult pregnancy Incompetent cervix Spotting with pregnancy

Pelvic Inflammation Sexually Transmitted Disease (date and type)_____

Dry vagina (without menopause) Difficult menopause_____

Cancer( cervix, bladder, uterus, ovarian, bladder, bowel) Cysts (ovarian breast)

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?_____

**MENOPAUSE** (Circle the symptoms that apply to you)

Hot flashes Insomnia Fatigue Memory Loss Mood swings Irritability Vaginal discharge (describe):

Dry Vagina Fatigue Depression Spotting (menses) Flooding Clotting Irregular menses Increased/Decreased Libido

Other symptoms not listed above_____

When did these symptoms begin:_____

Are they getting worse_____better_____same_____Last Menstrual period_____
__
Are you on/ or ever been on hormone replacement therapy?_____ if so, how long_____
ame and dose_____

Reason for stopping_____

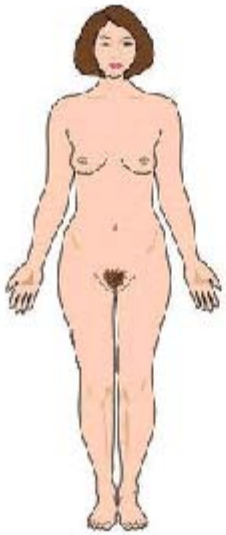
Other medications/herbal remedies_____

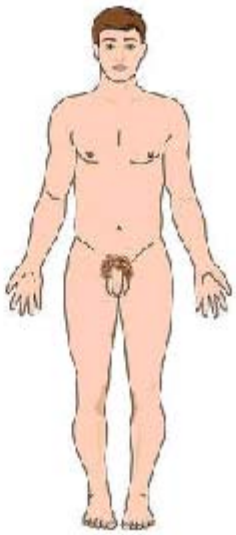
Age of Mother at menopause:_____Concerns/Experience_____

What would you like to tell us about your pain that we have not asked? Comments:

# Anatomy Issue Indicator

Mark areas of complaint





**Please read and sign**

I understand that payment is due at the time of treatment unless arrangements have been made other wise.

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_____

**Client Confidentiality Release Form**

Due to the HIPAA regulations all practitioners should have a signed release form from their client before taking any notes about them. The best way to be fully compliant would be to get this release signature at the initial consultation.

Certification candidates should have this form signed before taking any notes. Clients should receive a copy of the form they signed, 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 _____

Phone_____email_____

give my permission, for my therapist/practitioner, *Lisa Kelly, LMT* to take notes about me, including health history/ medical and /or personal information I choose to disclose to him/her.

.

I understand that this information may be used for the purpose of practitioner certification and will be shared with the Arvigo Institute, LLC.

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

Signature: _____ Date: _____

Revised on 06/09/07