The Arivgo Techniques of Maya Abdominal Therapy™

CONFIDENTIAL INTAKE FORM

Date of Initial Visit_____

Name_____

Address_____

City_____ 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 by **cash or check** at the time of treatment unless arrangements have been made otherwise.
I agree to give at least 24 hours notice of cancellation of appointment
Cases of extreme emergency are considered exceptions to this cancellation policy as well as changes in the menstrual cycle.
I understand that as a midwife, Jaime Shapiro LM CPM may be called to a birth the day of my appointment, and will try to give me as much notice as possible about a cancellation.
I understand the treatment here is not a replacement for medical care.
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 Jaime Shapiro LM CPM updated on my health.

Client signature:_____Date_____

Jaime's signature:_____Date_____

The Health Insurance Portability and Accountability Act (HIPAA), which protects an individual's identifiable health information, requires you to give release to your health care providers to takes notes about your medical, personal and health history.

I, (name)_____address _____

give my permission, for my therapist, Jaime Shapiro LM, to take notes about me, including health history/ medical and /or personal information I choose to disclose to her.

I understand that this information may 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: _____

CLIENT HEALTH HISTORY

Name _____ Age_____ DATE of First Appointment _____

Address_____

Home phone _____Cell/work phone _____

Emergency contact _____& phone number _____

How did you hear about Peaceful Passage Midwifery & Maya Abdominal Therapy™? _____

Gender **M** or **F** Your age _____Your Occupation_____

Marital status _____ If not married, do you have a significant other? _____ Children? ___ Ages _____

DATE of birth _____ e-mail address _____

What alternative therapies have you experienced? _____

How long ago? _____ Frequency? _____ Do you stretch? _____ How often? _____

Do you exercise regularly or participate in sports? ____ What? _____ How often? _____

What is your current stress level? (low) 1 2 3 4 5 (high) Is the stress: positive or negative or both?

How many hours do you sleep each night? _____ Do you usually wake feeling: rested? tired? other? ____

ANXIOUSNESS: **Often Sometimes Seldom** DEPRESSION: **Often Sometimes Seldom**

What is your major area of pain and/or concern? _____

When did you first notice it? _____ What brought it on? _____

What activities aggravate it? _____ Is this condition getting worse? _____

Does it interfere with: work? ____ sleep? ____ recreation? ____

At or around the time of the onset were there emotional stresses occurring? _____

What have you done to get relief? _____

Have you sought a diagnosis? _____ Diagnosis _____

By whom? _____

Other areas of pain and/or concern _____

FOR OFFICE USE ONLY:

FERT./PRECONC. MENSTR. PELV. ABO./DIG. PREG. MISC. BIRTH. PP.

Digestion and Diet

Typical breakfast _____lunch_____

dinner_____ snacks_____

How many meals per week do you eat fast food, takeout, or dine out? _____

How many times per week do you have:

____ beef ____ chicken ____ fish ____ pork

____ white bread ____ white rice ____ crackers/chips/pretzels

____ cow milk ____ ice cream ____ cheese ____ other dairy

____ desserts ____ canned food ____ soda pop

Do you add salt to your food? _____ What would you say is the worst thing you eat? _____

Indicate the following habits with the applicable letter: **H**-heavy **M**-moderate **L**-light **N**-none

Alcohol____ Coffee____ Tea____ Colas____ Tobacco____ Marijuana____ other____

How much WATER do you drink per day? _____

Are you subject to binge eating? _____ On what foods? _____

What food do you find to be your weakness? _____

Appetite (circle one) **GOOD FAIR POOR** Digestion (circle one) **GOOD FAIR POOR**

Do you experience bloating/gas after meals? _____ Do you have sour burps? _____ heartburn? _____

Do you feel SLEEPY after meals? _____ If so, how often? _____

Are you on a restricted diet? _____ Please explain _____

How often do you have a BOWEL movement? _____ Do your stools: **sink** or **float** or **both** ?

Have you ever had: hard stools? _____ how often? _____ loose stools? _____ how often? _____

URINATION (circle as applicable)

NORMAL SCANTY More than 5 times daily BURNING STRONG ODOR DARK COLOR

Typical COLOR _____

Is there any history of bladder or kidney infections? _____ If so, at what age? _____

Family History

	Alive?	Age/Cause of Death	Major ailments while alive
MOTHER			
Maternal Grandmother			
Maternal Grandfather			
FATHER			
Paternal Grandmother			
Paternal Grandfather			

(OPTIONAL) Is there a history of abuse in your family? ____ (circle) emotional physical sexual spiritual

Is there a history of: drug abuse alcohol abuse suicide in your family? (Please circle as applicable.)

Emotional and Spiritual

If romantically involved, how is your relationship? _____ Is your love life satisfying? _____

Were/are there any emotional traumas in your early or present life? (ie. rape, great loss, suicide, death of a loved one, etc.) _____

If possible, please explain the negative emotion you experience most _____

When do you most often feel this emotion? _____

Where are you when you feel this emotion? _____

What is your opinion of yourself? _____

Have you ever been to counseling? _____ How was this helpful?_____

Do you pray ? _____ If so, how often? _____ Do you meditate? _____ If so, how often? _____

RATE Yourself: **N** none **S** - some **L** lots

Faith_____ Hope_____ Charity_____ Generosity_____ Sense of humor_____ Sense of fun_____

Is there an unrealized longing in your life? _____ If so, what is it? _____

Are you involved in activities outside of work? ___ If so, what type? _____

Hobbies and/or interests _____

Birth and Early Childhood

My birth was: (circle one) Normal Difficult Unknown

Please explain _____

Briefly explain your early relationship with each of your parents _____

_____

Briefly explain your present relationship with each of your parents _____

_____

Medical History

What is your blood type? (A, AB, B, O) _____

Are you currently under the care of a doctor, chiropractor or other health care practitioner? _____

If so, for what condition? _____

Name of practitioner/clinic _____

City _____ State _____ Phone _____

List any medications you are taking _____

For how long? _____ Do you have allergies? _____

Previous broken bones including year _____

Previous accidents including year _____

Previous surgeries including year _____

Other hospitalizations including year _____

Childhood accidents or physical traumas _____

List any medications you took as a child and how long taken _____

Have you ever hit or fallen on your head or tailbone? _____

Did you suffer trauma at birth? _____

Do you or have you ever had an **inguinal hernia** or surgery for an inguinal hernia? _____

Please explain _____

Do you or have you ever had a **hiatal hernia**? _____ Explain _____

CIRCLE any of the following you are CURRENTLY experiencing.

Underline any you have had as a Past problem.

headaches	asthma	contact lenses or dentures	constipation
allergies	fatigue	arthritis, osteoporosis, brittle bones	pregnancy
diabetes	hepatitis	varicose veins/other circulatory problems	cold hands
swollen ankles	sinus trouble	heart pain	cold feet
painful joints	swollen joints	face flushed	tightness in shoulder muscles
fainting spells	emotional problems	anorexia/bulimia	heart problems
kidney problems	bad breath	ringing in ears	tightness in throat
loss of smell	loss of taste	muscle spasms in neck	grating in neck
blood clots/phlebitis	loss of memory	frequent cold or flu	numb hands or feet
head feels too heavy	pinched nerve in back	herniated or bulging disc	epilepsy or other seizures
pains in legs and feet	shooting pain in head	high or low blood pressure	spinal problems
pins & needles in legs	pins & needles in back	pins & needles in arms and hands	sciatica
painful menstruation/cramps		lung or breathing problems	cancer
skin disorders, acne, fungus, rash		sensitivity to oils and lotions	depression

Your Menstrual Pattern:

_____ Painful periods

_____ Late, early, or irregular

_____ Dark, thick blood at onset or end of menstruation

_____ Dizziness with period

_____ Headache or migraine with period

_____ Excessive bleeding (more than one pad per hour)

_____ Blood clots during menstruation

_____ PMS/Depression with or before period

_____ Failure to ovulate regularly

_____ Painful ovulation

_____ Bloating or water retention with period

Do you experience heaviness in the lower pelvis as **menses begin**? _____

Do you experience heaviness in the lower pelvis **during ovulation**? _____

How many days does your period last? ____ Do you experience NO periods at all?_____

Explain_____

Have you experienced a period every two weeks within the past few years?_____

Have you taken hormone replacement therapy? ____ If so, for how long?_____

Check other signs or symptoms that apply:

Varicose veins of the legs _____

Numb legs and feet especially when standing still _____

Constipation _____

Low back ache _____

Cervical polyps _____

Uterine polyps _____

Uterine fibroids _____

Uterine infections _____

Frequent urination _____

Vaginal discharge _____ (color/how often?) _____

Vaginal yeast conditions/vaginitis _____

Chronic miscarriages _____

Premature deliveries _____

Weak newborn infants _____

Endometriosis _____

Difficult pregnancy, "incompetent" uterus _____

Tired weak legs _____

Sore heels when walking _____

Painful intercourse _____

Hot flashes _____

Mood swings _____

Memory loss _____

Depression _____

Difficult menopause _____

Bladder infections _____

Insomnia _____

Fatigue _____

Spotting _____

Pelvic inflammation _____

Ovarian or breast cysts _____

Endometritis _____

Sexually transmitted disease _____

Dry vagina with or without menopause _____

Cancer of the cervix, uterus, bladder, or lower bowel (circle) _____

List any other symptoms not included on list: _____

How many pregnancies have you had? _____ Number of deliveries? _____

Date(s) of deliveries _____ How many children? _____

Were there any complications? _____

What was pregnancy like for you?_____

labor? _____

delivery?_____

Did you nurse your babies? _____

If so, what was your experience?_____

Have you had any miscarriages? _____ Have you had any abortions?_____

If so, how many and when_____

Have you processed/grieved those losses?_____

What medications did your mother take when she was pregnant with you?_____

Do any of the **women on your mother's side of the family** suffer from any of the following:

Fertility issues _____ Menstrual problems _____ Difficult childbirth _____

Difficult menopause_____ Cancer _____ Heart trouble _____

Are you currently pregnant?_____ If yes, how many weeks are you? _____

Are you hoping to become pregnant in the future?_____

Do you now or have you ever had fertility challenges? _____

Are you now or have you ever taken birth control pills? _____

When and for how long? _____

Did you experience any issues on them? _____

If any, what type of birth control methods do you currently use? _____

Are you presently or have you recently been under a doctor's care for gynecological problems? _____

Explain _____

Please list any serious falls or accidents in childhood or as an adult especially those that involved your tailbone, back, head, or any whiplash please explain: _____

_____

Rate your interest in sex: **High** _____ **Moderate** _____ **Low** _____ **None** _____

Do you have difficulty achieving orgasms? _____ Explain _____

Were you ever raped or sexually abused? _____ At what age did this occur? _____

Are you a survivor of incest? _____

Have you undergone counseling for rape, sexual abuse or incest? _____

SUPPLEMENTS

Please list any supplements, herbs, vitamins, or natural products you are presently taking: