The Arvigo Techniques of Maya Abdominal Therapy®
Confidential Intake Form

Date of initial visit ____.____.____

Name _____ Pronoun _____

Legal Name (if different from above)

_____

Address _____

Preferred phone number _____

Email _____ Date of birth _____

Occupation _____

Emergency contact name and phone number

_____

How did you find me? _____

Client Confidentiality and Release Form

I, (name)_____, give my permission for this practitioner to take notes including health history/medical and/or personal information I choose to disclose to her and that this information will be treated as confidential. Furthermore, I understand that massage/bodywork should not be construed as a substitute for medical care. I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment, I am subject to a fee equal to the cost of the missed appointment.

Client Signature _____ Date: _____

Practitioner Signature _____ Date:_____

A parent or legal guardian must give informed written consent for any client under age 18.

Reasons for Visit

Primary reason for visit _____

When did you first notice it? _____

Are there any causes or patterns you noticed? _____

_____

Was there an emotional, spiritual or physical event(s) that occurred around the onset? _____

_____

Are there activities that provide relief? _____

Are there activities that make it worse? _____

Is this condition worsening? _____

Does it interfere with work? _____ Sleep? _____ Recreation? _____

Have you had massage/bodywork before? _____

If so, when and what type? _____

Medical History

Are you under the care of another health care practitioner(s)? Yes No

Reasons(s) _____

_____

Name of practitioner(s) _____

Practitioner's phone _____ Email _____

Current medications and/or supplements/remedies _____

_____

Please specify any medicinal allergies, sensitivities and adverse reactions

_____

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

_____

Hospitalizations _____

Accidents or traumas (car accident, joblessness, death of a loved one, sexual assault, etc.) _____

_____

Please describe any falls and/or injuries to the head, sacrum or tailbone ____

_____

Please circle any symptoms that apply to you, and mark whether they are "Past" or "Present." Please fill in any relevant blanks.

Asthma
Past ___ Present ___

Cancer
Type:_____
Past ___ Present ___

Cold hands or feet
Past ___ Present ___

Contact lenses
Past ___ Present ___

Dentures/partials
Past ___ Present ___

Difficulty falling asleep, staying awake or waking up
Past ___ Present ___

Fainting spells
Past ___ Present ___

Feeling down, less interest in usual activities, differences in sleep or appetite
Past ___ Present ___

Headaches
Type: _____
Past ___ Present ___

Hemorrhoids
Past ___ Present ___

Herniated/bulging discs
Past ___ Present ___

High or low blood pressure

Past ___ Present ___

Low back pain
Past ___ Present ___

Muscular tension
Location: _____
Past ___ Present ___

Numbness in feet or legs when standing
Past ___ Present ___

Prosthesis or artificial limb(s)
Past ___ Present ___

Sciatica
Past ___ Present ___

Seizures
Past ___ Present ___

Sinus conditions, frequent colds
Past ___ Present ___

Skin ailments
Past ___ Present ___

Sleep disturbance
Past ___ Present ___

Sore heels when walking
Past ___ Present ___

Swollen ankles
Past ___ Present ___

Varicose veins
Past ___ Present ___

Worry, restlessness
Past ___ Present ___

Family of Origin History (If known)

	Still living?	Cause of death/age?	Major health issues?
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Digestion and Elimination

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Typical snacks _____ Water intake (8oz glasses/day) _____

Please circle "Yes," "Sometimes" or "No" for the following.

Caffeine: Yes Sometimes No If so, how often and what quantity? _____
Tobacco: Yes Sometimes No If so, how often and what quantity? _____
Alcohol: Yes Sometimes No If so, how often and what quantity? _____
Marijuana: Yes Sometimes No If so, how often and what quantity? _____

Have you sought support for substance recovery? _____

Least nutritious snack in your diet _____

What foods do you wish you ate less? _____

Have you ever experienced binge eating? _____
If so, with what foods? _____

Do you experience bloating/gas/burps after eating? _____

What foods trigger this? _____

How often are your bowel movements? _____

Do you experience pain when eliminating? _____

Does your stool sink or float? _____ Do you experience constipation? _____ Blood in stool? _____ Mucus in stool? _____

Emotional and Spiritual

How would you describe yourself? _____

_____

If possible, please describe the most difficult/hurtful emotion you experience

_____

In what situations do you most often feel this emotion? _____

_____

Do you have a spiritual practice (prayer, ritual)? _____

If so, what is it? _____

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 humor ____
Fear ____ Grief ____ Sense of fun ____

Other (Describe briefly.) _____

What hobbies/activities provide you with pleasure and fulfillment? _____

_____

Describe your exercise routine (type, frequency). _____

_____

What would you like to feel different in your body, mind, emotion or spirit and/or in your life in the next 6 months? _____

_____

One year? _____

Sexual and Reproductive Health

If any questions feel irrelevant, please feel free to skip them.

Method of contraception: (Please circle none or multiple.)

Abstinence Condoms Diaphragm Fertility awareness Injection
IUD Patch Pills Rhythm method Other

Length of time using method _____

Date of last Pap smear _____

Results of last Pap smear _____

Are you seeking support around fertility? _____

Please describe current support to date (IUI, IVF, etc.). _____

_____

_____

Menstrual History

Age of first menstruation _____ What was this like for you? _____

_____

Date of last menstrual period _____ Length of menstrual cycle _____

Are you currently actively trying to conceive? _____

Check all that apply indicating "past" or "present," and "location" if relevant.

Bladder

□ Cysts
Location _____
Past ___ Present ___

□ Nocturnal urination
How many times per night?
Past ___ Present ___

□ Pain or burning with urination
Past ___ Present ___

□ Urinary incontinence/dribbling
Past ___ Present ___

□ Urinary infection
Past ___ Present ___

□ Water retention
Past ___ Present ___

□ Weak or interrupted urine flow
Past ___ Present ___

Ovaries

□ Bloating
Location _____
Past ___ Present ___

□ Cysts
Location _____
Past ___ Present ___

□ Painful ovulation or lack of ovulation
Location _____
Past ___ Present ___

Penis

□ Cysts
Location _____
Past ___ Present ___

Rectum

□ Cysts
Location _____
Past ___ Present ___

Prostate

□ Cysts
Location _____
Past ___ Present ___

Testicles

□ Cysts
Location _____
Past ___ Present ___

Uterus

□ Bloating
Past ___ Present ___

□ Cysts
Location _____
Past ___ Present ___

□ Dark thick blood at Menstruation
Beginning ___ End ___
Past ___ Present ___

□ Endometriosis
Location, if known ___
Past ___ Present ___

□ Excessive bleeding
Pads per hour _____
Past ___ Present ___

□ Fibroids
Location, if known ___
Past ___ Present ___

□ Headaches or migraines with menstruation
Past ___ Present ___

□ Heaviness in pelvis prior to menstruation
Past ___ Present ___

□ Irregular cycles
Early ___ Late ___
Past ___ Present ___

□ Painful intercourse
Past ___ Present ___

□ Painful periods
Past ___ Present ___

□ Skipped menstrual cycle
How long? _____
Past ___ Present ___

□ Uterine or cervical polyps
Past ___ Present ___

□ Uterine infections
Past ___ Present ___

□ Vaginal dryness
Past ___ Present ___

□ Vaginal infections
Past ___ Present ___

Pregnancy History

Are you currently pregnant? Yes No • If Yes, how many weeks? _____

Have you been pregnant before? Yes No

If so, how many pregnancies? _____ How many births? _____

Please list the birth dates _____

Were any of the births premature? Yes No Did you have any complications in any pregnancy? _____

Please circle what (if any) complications apply to you.

Spotting during pregnancy Weak newborns at birth Challenged cervix

Premature births Miscarriages Terminations Other complications

Briefly describe experiences with:

Pregnancy _____

Labor _____

Birthing _____

Postpartum _____

Maternal Family of Origin History: *Please circle what applies to you.*

Fertility challenges Fibroids Endometriosis PMS

Menopause Cancer Menstrual challenges Other

Were there any medications your mother took when she was pregnant with you? _____ If so, what were they? _____

Are you aware of any negative events or emotions related to your birth? ____

Please explain. _____

_____

Indicate your interest in sex. High ____ Moderate ____ Low ____ None _____

Do you have or have you ever had difficulty experiencing orgasms? _____

_____

Have you experienced the following? Emotional abuse _____ Incest _____

Rape _____ Trauma _____ Violence _____

If so, how recently? _____

What support did you receive around your experience, if any? _____

_____

What impact does this currently have on your life? Please circle one.
None Some impact Every day Very impactful

Comments _____

_____

_____

Hormonal Changes/Menopause

Are you currently or have you ever have been on hormone therapy? _____

If so, for how long? _____ Name and dosage _____

Reason for stopping _____

If menopausal, age symptoms began _____

Please circle if the symptoms are getting: Worse Better Same

Age of mother at menopause _____ Concerns/experiences of the process

_____

Please check the symptoms that apply to you.

- ☐ Hot flashes
- ☐ Insomnia
- ☐ Dry vagina
- ☐ Flooding
- ☐ Irregular menstrual cycles
- ☐ Vaginal discharge
- ☐ Spotting
- ☐ Increased/decreased libido
- ☐ Memory loss
- ☐ Fatigue
- ☐ Mood swings
- ☐ Painful intercourse
- ☐ Irritability
- ☐ Worry, restlessness
- ☐ Feeling down, less interest in usual activities, difference in sleep or appetite
- ☐ Difficulty falling asleep, staying awake, or waking up
- ☐ Weight gain
- ☐ Weight loss

On the following page, please share any additional information you feel is important that isn't mentioned above