majabetts
WOMEN'S WELL-BEING

The Arvigo Techniques of Maya Abdominal Therapy™

Confidential Intake Form

Date of initial visit	

Name			
Address			
State		Postcode	
Home Phone		Mobile Phone	
Email			
Date of birth		Age	
Occupation		Marital Status	
Gender		Referred by	

Client Confidentiality and Release Form

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations (unless specified under his/her professional scope of practice). The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client before taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

I, (name)_____

give my permission, for my practitioner to take notes 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/or may be shared with the Arvigo Institute, LLC for statistical data collection only. All relevant identifying information will not be disclosed, such as name, address, social security number, date of birth.

Client Signature	
Practitioner signature	

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

majabetts
WOMEN'S WELL-BEING

Reason for Visit

Primary reason for visit						
When did you 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?						
Does it interfere with	Work		Sleep		Recreation	
What type of massage or bodywork have you had before?						

Medical History

Are you currently under the care of another health care provider(s)?			
Reason (s)			
Name of practitioner			
Address			
State		Postcode	
Phone		Email	

Current Medications and /or Supplements/Remedies		
Allergies: allergen and reaction		
Surgical history & recent procedures	Year	Type
Hospitalisations		
Accidents or trauma		
Falls or injuries to sacrum/ head/tailbone		
Other		

Please review and check the following:

	Past	Present
Headaches		
Cold Hands or feet		
Swollen ankles		
Frequent Colds		
Seizures		
Fainting Spells		
Muscular Tension: Type		
Varicose Veins		
Sciatica		
Painful/Swollen Joints		
High or Low Blood Pressure		
Dentures/Partials		

	Past	Present
Numbness in feet or legs if standing		
Sore heels when walking		
Anxiety		
Depression		
Sleep Disturbance		
Low Back Pain		
Skin Disorders: Type		
Haemorrhoids Location		
Herniated/Bulging Discs		
Artificial/Missing limbs		
Contact Lenses		
Cancer (past or current) Type		

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

majabetts
WOMEN'S WELL-BEING

Family History

Family Member	Living?	Cause and Age of Death	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Gastrointestinal Health History

Describe your typical intake each day:

Breakfast	
Lunch	
Dinner	
Snacks	
Water	
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?	
Food Allergies?		Describe	
How often are your bowel movements?		Do your stools sink or float	
Constipation?		Blood in stool?	
Mucus in stool?		Pain when stooling?	
Diarrhoea?		Other?	

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

majabetts
WOMEN'S WELL-BEING

Lifestyle, Emotional & Spiritual

What is your opinion of yourself	
Describe the most positive emotion you experience	
When and where do you experience this emotion	
Describe the most negative emotion you experience	
When and where do you experience this emotion	
Describe your spiritual and/or religious practice	

On a scale of 1 - 10 (1 being the lesser, 10 the greater) Please rate yourself in each of these qualities:

	1	2	3	4	5	6	7	8	9	10
Faith										
Hope										
Charity										
Generosity										
Sense of Humour										
Fear										
Grief										
Sense of Fun										

What hobbies/ activities provide you with pleasure and accomplishment		Describe your exercise routine (type, frequency)	
What changes would you like to achieve in? • 6 months		What changes would you like to achieve in? • 1 year	
Do you use tobacco? Packs per day		Do you drink alcohol? Units per day	
Do you use marijuana Quantity		Other?	
Have you been under treatment for substance use?			

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

majabetts
WOMEN'S WELL-BEING

Female Reproductive Health History

Method of Contraception							
pills		patch		diaphragm		injection	
condoms		IUD		abstinence		rhythm method	
fertility aware		other		time using			
Last Pap smear							
Results							
Are you now or have you in the past experienced fertility challenges							
Y / N	Treatment	IUI, IVF, etc.					

Menstrual History Review and check as indicated

Age of menses		What was this like for you?	
Last menstrual period		Length of menses	
Are you trying to conceive		Are you or could you be pregnant	

	Past	Present
Painful periods		
Heaviness in pelvis prior to menses		
Excessive bleeding Pads per hour		
Dizziness		
Water retention		
Endometriosis location		
Uterine or cervical polyps		
Vaginal infection(s)		
Bladder Infection(s)		
Painful intercourse		
Episodes of amenorrhea? How long?		

	Past	Present
Irregular cycles • Early • Late		
Dark, thick blood at: • Beginning • End • Both		
Headache or migraine with menses		
Bloating		
Ovulation: • Painful • Failure to		
Fibroids location		
Uterine infection(s)		
Cysts location:		
Urinary incontinence		
Vaginal dryness		

Interest in sex							
High		Moderate		Low		None	
Difficulty experiencing orgasms?							
Have you experienced trauma?			Describe				
Did you undergo counselling for this							
What was this like for you?							

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

majabetts
WOMEN'S WELL-BEING

Pregnancy History

Number of Pregnancies		Dates	
Miscarriage		Dates	
Termination(s)		Dates	
Number of Births		Dates	
Complications for any of the above			
Premature Births?		Spotting During Pregnancy	
Weak New-borns?		Incompetent Cervix?	

Describe your experience with:

Pregnancy	
Labour	
Birthing	
Post-Partum	

Maternal Family History

Infertility		Fibroids		Endometriosis		PMS	
Menopause		Menstrual Problems					
Other				Cancer (type)			
Medications your mother took when she was pregnant with you (if any)							
Your Birth Trauma (if known)							

Menopause

Age symptoms began		Are they getting: • worse • Better • same	
Are you on/ or ever been on hormone replacement therapy		if so, how long	
Name and dose			
Reason for stopping			
Age of Mother at menopause			
Concerns/Experience			

Check the following symptoms that apply to you:							
Hot flashes		Insomnia		Fatigue		Memory loss	
Mood swings		Vaginal discharge		Dry vagina		Depression	
Anxiety		Irritability		Spotting		Flooding	

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

majabetts
WOMEN'S WELL-BEING

Male Reproductive Health History

	Past	Present
Painful urination		
Urinary incontinence or dribbling		
Weak or interrupted Urine flow		
Pain or burning with urination		
Nocturnal urination How many times?		
Pain in lower back, especially after intercourse		
Pain or discomfort in: • Penis • Testicles • Rectum		
Frequent Bladder or Kidney Infections When?		

	Past	Present
Urinary retention		
Difficult starting or holding urine stream		
Blood or pus in urine		
Pelvic pressure		
Insatiable sex drive		
Pain or discomfort between scrotum and testicles		
Pain or Discomfort in Inner thighs: • Left • Right • Both		
Erection: Difficulty in obtaining Maintaining Painful ejaculation		

Results of PSA (prostate specific antigen) test		Date done	
Results of Sperm count (if applicable and known		Date done	
Family history of prostate disease		Relationship	
Family history of cancer		Type	
		Relationship	
Sexually transmitted disease		Type	

Interest in sex							
High		Moderate		Low		None	
Difficulty experiencing orgasms?							
Have you experienced trauma?			Describe				
Did you undergo counselling for this							
What was this like for you?							

Additional Comments:

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