



The Arvigo Techniques of Maya Abdominal Massage Female Intake Form

(please print)

First & Last Name Today's Date

Street Address City State Zip

Phone Number Email Address Ht Wt Sex Age Date of Birth

Your Occupation/Employer Emergency Contact (Name & Phone Number)

Primary Care Physician (Name, Practice, Location)

OB/GYN or Urologist (Name, Practice, Location)

Reproductive Endocrinologist (Name, Practice, Location)

How did you hear about us? (doctor, nurse, friend, website, flyer)

In case of a Press Event, would you be willing to share your story? Yes No

If YES, please check which of the following we could contact you about:

- Print/Interview TV Radio Testimonial

Health History

What are the health problems for which you are seeking treatment?

How long have you had this condition?

What other forms of treatment have you sought?

Please list any surgeries or major health incidents (year and type)

Hospitalizations (year and type)

Accidents or Traumas

Falls/Injuries to Sacrum/Head/Tailbone (describe)

Birth Trauma, if known

Family Medical History _____

Alive?	Age/ Cause of Death	Major Health Issues
Mother <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Father <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
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Siblings <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
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Family history of abuse (circle if applicable) physical emotional sexual spiritual

Family history of Substance Abuse Suicide Other Trauma, please explain _____

Digestion & Elimination

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Snacks _____

Water (glasses/day) _____ Caffeine _____

Do you experience bloating/gas/burps after eating? Yes No

If yes, what foods trigger this? _____

How often are your bowel movements? _____

Do your stools Sink Float Do you Experience Constipation Blood in Stool Mucus in Stool Pain

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 _____ Generosity _____ Sense of Humor _____

Sense of Fun _____ Fear _____ Grief _____ Sadness _____ Anger _____

Other (describe briefly) _____

What hobbies/ activities provide you with a sense of pleasure and accomplishment? _____

What changes would you like to achieve in 6 months? _____

One Year? _____

Medical History

Are you currently receiving medical treatment? Yes No

If Yes, for what condition? _____

Please list any current medications _____

Supplements/Herbal Remedies _____

Allergies: specify allergen and reaction _____

Tobacco? Yes No Quantity _____ Alcohol? Yes No Quantity _____

Marijuana? Yes No Quantity _____ Other _____

Have you been under treatment for substance use? Yes No If yes, describe _____

Check any of the following you are *currently* experiencing.

Underline any of the following you have experienced in the *past*.

- | | |
|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High or Low Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Colds/Upper Respiratory Conditions |
| <input type="checkbox"/> Artificial/Missing limbs | <input type="checkbox"/> Headaches: migraine, tension, cluster _____ |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Herniated or Bulging disc: (location) _____ |
| <input type="checkbox"/> Contact lenses | <input type="checkbox"/> Muscle Tightness: (location) _____ |
| <input type="checkbox"/> Dentures | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pins and needles in arms, legs, hands or feet |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Skin Disorders: Acne, Fungus, Eczema, Psoriasis: (location) _____ |
| <input type="checkbox"/> Fatigue | _____ |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Spinal Problems |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Swollen Joints: (location) _____ |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Sinus Conditions |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Sinus Conditions | <input type="checkbox"/> Other: _____ |

Female - Reproductive Health History

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

Maternal Family History of Infertility Fibroids Endometriosis Menstrual Problems Menopause

PMS Cancer(type) _____

Age of Menarche _____ What was this like for you? _____

Are you currently undergoing fertility treatment? Yes No Drug protocol? Yes No

If yes, describe _____

Number of Pregnancie(s) _____ Number of Deliverie(s) _____ Dates _____

Termination(s) When _____ Miscarriage(s) When _____

Complications _____

What was your experience of:

Pregnancy _____

Labor _____

Delivery _____

PostPartum _____

Method of Contraception: Pill Patch Ring IUD Diaphragm Injection Condoms Abstinence

Rhythm Method Other _____

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

Date of Last Pap Smear _____ Results (if known) _____

Date of Last Period _____ Length of Menses _____

Number of Days in Cycle _____ On what day do you ovulate _____

Any episodes of amenorrhea? Yes No If yes, when _____ for how long _____

Symptoms with Period: check all that apply:

Bloating/water retention

Breast Tenderness

Dizziness

Failure to Ovulate

Headache or migraine

Irregular (late or early)

Painful Periods

PMS/Depression: with or before period

Dark, thick blood: beginning or end of period

Painful Ovulation

Heaviness or pressure in lower pelvis

Headache or migraine

Excessive Bleeding (> one pad/hour)

Other Symptoms (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Difficulty sitting for long periods |
| <input type="checkbox"/> Difficult Pregnancy | <input type="checkbox"/> Dry Vagina (without menopause) |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Fibroids, size and location, if known _____ |
| <input type="checkbox"/> Chronic Miscarriages | <input type="checkbox"/> Incompetent Cervix Cysts (ovarian/breast) |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Numb legs and feet when standing still |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Pelvic Pain, describe _____ |
| <input type="checkbox"/> Low back ache | <input type="checkbox"/> STDs, type and date _____ |
| <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Spotting with Pregnancy |
| <input type="checkbox"/> Pelvic Inflammation | <input type="checkbox"/> Tired/westless legs |
| <input type="checkbox"/> Premature Deliveries | <input type="checkbox"/> Vaginal discharge, describe _____ |
| <input type="checkbox"/> Sore heels when walking | <input type="checkbox"/> Vaginitis or Vaginal Yeast infections |
| <input type="checkbox"/> Uterine Polyps | <input type="checkbox"/> Varicose veins of leg |
| <input type="checkbox"/> Uterine infections | <input type="checkbox"/> Weak Newborns |

Rate your interest in Sex: High Moderate Low None

Do you have or ever had difficulty experiencing orgasms? Yes No

Have you experienced Rape Trauma Incest If so, when _____

Did you undergo counseling for this? Yes No

What was this like for you? _____

Additional Comments _____

Consent for Care

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's Signature

Date