



The Arvigo Techniques of Maya Abdominal Massage Male 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	_____	_____
Siblings <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

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: _____ |

Male - Reproductive Health History

Please check and describe any symptoms that apply:

- Difficulty sitting for long periods _____
- Family history of cancer, type and relationship _____
- Family history of prostate disease, type and relationship _____
- Low back pain _____
- Numb/achy/ antsy legs or feet _____
- Sore Heels _____
- STDs, when and type _____
- Varicose Veins, location _____

Rate your interest in sex High Moderate Low None

Do you ever have difficulty achieving orgasm? 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? _____

Urinary Symptoms (check all that apply):

- Bladder/Kidney infections Frequent Urination Painful urination
 - Nocturnal Urination, frequency _____
 - Changes in urinary systems (describe flow, stream, strength of stream) _____
- When did you first notice these symptoms? _____
- Are they getting better or worse, describe _____

Erectile Function (check all that apply):

- Difficulty obtaining an erection Difficulty maintaining an erection Painful ejaculation
- Is there a history of back injury/trauma? Yes No if yes, describe _____
- When did you first notice these symptoms? _____
- Are they getting better or worse, describe _____
- Current medications for supplements _____

PSA (Prostate Specific Antigen) Test date & results (if known) _____

Sperm Count date & results (if applicable and known) _____

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