

ATMAT CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Date of Initial Visit _____
Address _____ State _____ Zip _____
Home Phone _____ Work Phone _____ email _____
Date of Birth _____ Age _____ Occupation _____
Marital status _____ Referred by _____
Have you had massage/bodywork before? _____ What type? _____

REASON FOR VISIT

What is your primary concern? _____
What are other areas of concern? _____
When did your 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? _____ interfere with work _____ sleep _____ recreation _____
Describe your exercise routine (type, frequency) _____

FAMILY HISTORY

Alive? Age/Cause of Death Major Health Issues
Mother: _____
Father: _____
Siblings: _____
Maternal Grandmother _____
Maternal Grandfather _____
Paternal Grandmother _____
Paternal Grandfather _____
Family History of Abuse _____ circle if applicable : physical emotional sexual spiritual
Family History of Substance Abuse _____ Suicide _____ Other Trauma _____

DIGESTION & ELIMINATION

Typical Breakfast: _____
Typical Lunch: _____
Typical Dinner: _____
Snacks: _____ Water Intake(glasses/day) _____ Caffeine _____
What is the worse thing on 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? _____
How often are your bowel movements? _____ Do your stools: sink _____ float _____
Constipation? _____ Blood in stool? _____ Mucus in stool? _____ Pain when stooling? _____
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 _____ Charity _____ Generosity _____ Sense of Humor _____
Sense of Fun _____ Fear _____ Grief _____ Other (describe briefly) _____

What are hobbies/ activities that 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 under the care of another health care provider(s)? _____ Reason (s) _____

Name(s) of _____

Practitioner _____ Address: _____

Phone _____ email _____

Current Medications: _____

Allergies: specify allergen and reaction: _____

Supplements/Remedies _____

Do you use Tobacco? _____ Quantity _____ /ppd Alcohol? _____ Quantitiy _____ ounces/ day

Marijuana? _____ Quantity _____ Other: _____ Have you been under treatment for substance use? If so, describe: _____

Surgical History (year and type) _____

Recent Procedures: _____

Hospitalizations _____

Accidents or Traumas _____

Falls/Injuries to Sacrum/head/tailbone (describe) _____

Birth Trauma if known _____

Please, check the areas of your body that you give permission to receive massage:

Oback Olegs Ofcet Obuttocks Oarms Oabdomen Ochest Oneck Ohead Oface Ohands

CIRCLE any of the following conditions you are experiencing NOW.

UNDERLINE any of the conditions you have experienced in the PAST.

Musculo-Skeletal

bone/joint disease
tendonitis
bursitis
arthritis
osteoporosis
muscle spasms/cramps
painful/swollen joints
headaches/ migraines
jaw pain/TMJ
neck , shoulder pain
chest pain
arm, hand pain
low back, hip pain
leg, foot pain
scoliosis
sciatica
spinal problems
other _____

Circulatory

heart condition
heart pain
high blood pressure
low blood pressure
diabetes
blood clots
phlebitis
cold hands/feet
swollen ankles or feet
lymphedema
varicose veins
fainting
other _____

Digestive

eating disorders s
constipation
gas/bloating
IBS
diverticulitis
other _____

Nervous System

nerve compression
herniated/bulging disks
epilepsy/seizures
tinnitus (ringing in ears)
fatigue
numb hands/feet
pins & needles arms, hands, legs, feet
loss of smell or taste
other _____

Infectious Diseases

hepatitis _____
HIV _____
other _____

Respiratory

asthma
lung/breathing problems
respiratory allergies
sinus conditions
other _____

Skin

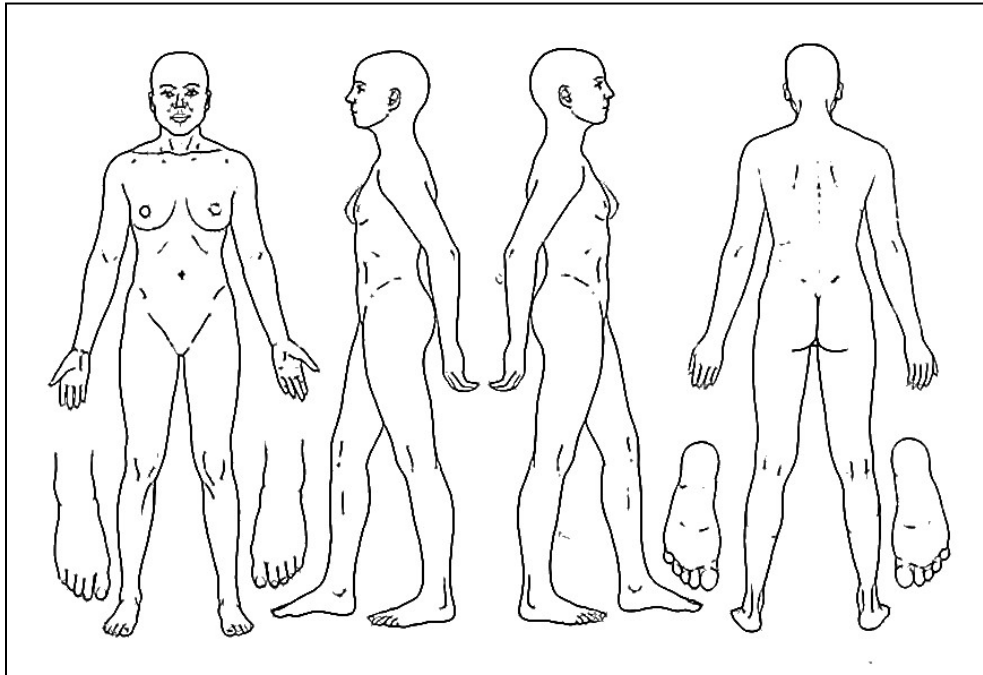
skin allergies
rashes
athletes foot
warts
psoriasis
acne
fungus
other _____

Other

anxiety fatigue
trouble sleeping
loss of memory
contact lenses
dentures
depression
kidney problems
cancer/tumors
drug/alcohol addiction
nicotine/caffeine addition
artificial /missing limbs
headaches

List any additional medical information which you feel is important for your therapist to know. __

Mark any areas of current persistent pain or tension on the figures below:



FEMALE ~ REPRODUCTIVE HEALTH HISTORY

Age of Menarche _____ What was this like for you _____

How many Pregnancie(s) have you had? _____ Number of Deliverie(s) _____ Dates _____

Termination(s) _____ When _____

Miscarriage(s)? _____ When _____

Complications _____

What was your experience of: Pregnancy _____

Labor _____

Delivery _____

Post Partum _____

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

Maternal Family History of (please circle)

Infertility Fibroids Endometriosis-----Cancer(type) _____

Menstrual Problems Menopause PMS

Method of Contraception (circle)

pills patch diaphragm injection condoms IUD abstinence rhythm method

Other: _____

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

Last Pap smear _____ Results (if known) _____

Date of Last Menstrual period _____ Length of Menses _____

Episodes of Amenorrhea _____ When _____ For how long _____

Please circle as appropriate:

Painful periods Irregular (late or early) Dark Thick Blood at Beginning or End of Cycle
Dizziness with period Headache or Migraine with period Excessive Bleeding (> one pad/hour)
PMS/Depression with or before period Failure to Ovulate Painful Ovulation
Bloating/water retention with period Heaviness or pressure in lower pelvis with period

Other Symptoms (Circle and Describe as indicated)

Varicose veins of leg Tired weak legs Numb legs and feet when standing still
Sore heels when walking Low back ache Painful intercourse Constipation Endometriosis
Endometritis Uterine Polyps

Fibroids (Size and Location if known) _____

Uterine infections Frequent urination Bladder infections

Vaginal discharge (describe) _____ Vaginitis Vaginal Yeast infections

Chronic miscarriages Premature deliveries Weak newborn infants Difficult pregnancy

Incompetent cervix Spotting with pregnancy Pelvic Inflammation
Sexually Transmitted Disease (date and type)_____ Dry vagina (without menopause) Difficult menopause
Cancer (cervix, bladder, uterus, ovarian, bladder, bowel) Cysts (ovarian breast)

Are you under the treatment for Infertility_____

Describe current treatment to Date:_____

Gynecological Provider:_____

Address_____ Phone_____

Rate your interest in Sex: High_____ Moderate_____ Low_____ None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced a history of rape_____ trauma_____ incest__ If so,-when_____

Did you undergo counseling for this_____

What was this like for you_____

MENOPAUSE (Circle the symptoms that apply to you)

Hot flashes Insomnia Fatigue Memory Loss

Mood swings Irritability Vaginal discharge (describe):

Dry Vagina Fatigue Depression Spotting (menses)

Flooding Clotting Irregular menses Increased/Decreased Libido

Other symptoms not listed above_____

When did these symptoms begin:_____

Are they getting worse_____ better_____ same_____ Last Menstrual period_____

Are you on/ or ever been on hormone replacement therapy?_____ if so, how long_____

Name and dose_____

Reason for stopping_____

Other medications/herbal remedies_____

Age of Mother at menopause:_____ Concerns/Experience_____

Additional Comments:

MALE ~ REPRODUCTIVE HEALTH HISTORY

Circle and Describe those symptoms as applicable

Headaches: Migraine _____ Tension _____ Cluster _____

Low back pain _____ Sore heels _____ Varicose Veins: Location _____

Numbness in legs/feet _____ Depression _____ Anxiety _____ Irritability _____

Family History of Prostate Disease: _____ Type _____ Relationship _____

Family History of Cancer _____ Type _____ Relationship _____

History of sexually transmitted disease _____ When _____ Type _____

Rate your interest in Sex: High _____ Moderate _____ Low _____ None _____

Do you have or ever had difficulty experiencing orgasms _____

Have you experienced a history of rape _____ trauma _____ incest _____ If so, -when _____

Did you undergo counseling for this _____

What was this like for you _____

Urinary Symptoms (circle those applicable)

Painful urination Bladder/Kidney infections

Frequent Urination Nocturnal Urination/ Frequency _____

Changes in urinary stream (describe flow, stream, strength of stream) _____

When did you first notice these symptoms _____

Are they getting better or worse _____ Describe _____

Erectile Function (describe as indicated)

Difficulty maintaining an erection _____

Painful ejaculation _____

Is there a history of back injury/trauma _____ Describe: _____

When did you first notice these symptoms _____

Are they getting better or worse _____ Describe _____

Current Medications or Supplements: _____

Results of PSA (prostate specific antigen) Test if known _____ Date done _____

Results of Sperm count (if applicable and known) _____ Date done _____

Additional Comments:

Please read and sign

I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel my well being is being compromised. If at any time I feel uncomfortable for any reason and feel the session needs to be ended, I will ask the therapist to cease the massage and the therapist will end the session.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrusts manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions of which I am aware and will update the massage practitioner of any changes in my health status.

The massage techniques that may be applied include ATMAT, myofascial release, trigger point release, soft tissue manipulation, hydrotherapy, hot/cold therapy, Swedish massage techniques, Chinese massage techniques, lymphatic massage and/or vibration-sound techniques.

I understand that payment is due at the time of treatment unless arrangements have been made other wise.
I agree to give at least 24 hours notice of cancellation of appointment. Cases of extreme emergency are considered exceptions to this cancellation policy. I understand the treatment here is not a replacement for medical care.
I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Therapeutic breast massage will not be performed on female clients unless she has given written consent.
Draping (a sheet to cover areas not being massaged) will be used during the session.

Clients under 17-years of age must provide THAI with the written consent of parent or guardian, who must also be present during the massage.

_____ signature of parent or guardian
_____ printed name

Client signature _____ Date _____

Therapist Signature: _____ Date _____

Client Confidentiality Release Form

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance.

Failure to comply with these confidentiality regulations could result in penalties.

I, (name) _____ address _____

Phone _____ email _____

give my permission, for my therapist/practitioner, _____

to take notes about me, including health history/ medical and /or personal information I choose to disclose to him/her.

I understand that this information may be used for the purpose of practitioner certification and will be shared with the Arvigo Institute, LLC .

I also understand that this information will anonymously be used for the Arvigo Institute, LLC . for statistical purposes, and that my practitioner may use this information to provide me with a summary for my own personal use.

Signature: _____ Date: _____

Revised on 5/25/2011