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 Ofeet 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

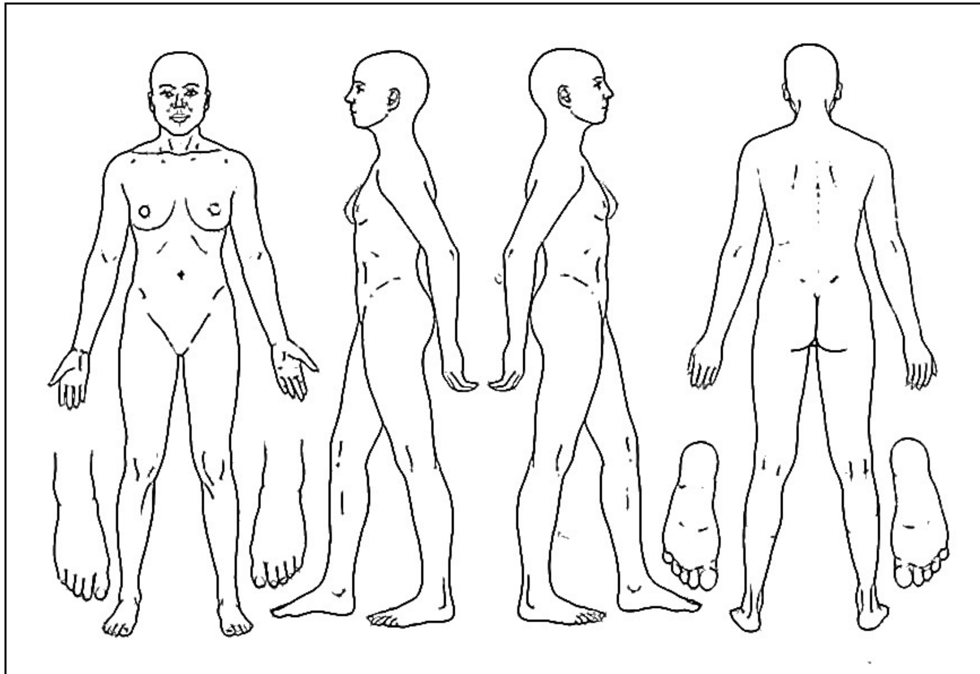
skin allergies
rashes
athletes foot
warts
psoriasis
acne
fungus
other________________

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 massages) 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