Date of Initial Visit: _____

Name: _____

Address:_____

Phone Number: _____ Email: _____

Date of Birth: _____ Occupation: _____

Female: _____ Male: _____ Other: _____ Preferred Pronoun: _____

Marital/Relationship status: _____ 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: _____ Date: _____

Practitioner Signature: _____ Date:_____

For Administrative Use Only

Client Initials: _____Case Study #_____Age_____ Anatomy: Male _____ Female_____

Date of Visit: _____ Practitioner Name_____

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? _____

Has the condition and/or symptoms been worsening? _____

Does the condition and/or symptoms interfere with: Work: _____ Sleep: _____ Recreation: _____

Have you had massage/bodywork before? _____ What type(s)? _____

Medical History

Are you currently under the care of another health care provider(s)? _____ Reason(s): _____

_____

Name(s) of Practitioner: _____ Phone Number: _____

Current Medications and /or Supplements/Remedies: _____

Allergies - specify allergen and reaction: _____

Surgical History (year and type) and/or Recent Procedures: _____

_____

Accidents or Traumas: _____

Hospitalizations: _____

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

Other: _____

_____

_____

_____

Please review and check or circle the following:

Headaches Type:	Past Present	Numbness in feet or legs when standing	Past Present
Asthma		Sore heels when walking	
Cold Hands or feet		Anxiety	
Swollen ankles		Depression	
Sinus Conditions Frequent Colds		Sleep Disturbance	
Seizures		Fainting Spells	
Low Back Pain		Muscular Tension: Location:	
Skin Disorders: Type		Varicose Veins Hemorrhoids Location	
Sciatica		Herniated/Bulging Discs	
Painful/Swollen Joints		Artificial/Missing limbs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Cancer (past or current) Type	

Other:

Family History

	Still Living?	**Cause and age of death**	**Major Health Issues**
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Digestion and Elimination Health History

Describe your typical:

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

Glasses Per Day of: Water _____ Caffeine: _____ Juice: _____ Carbonated Beverages: _____

Tobacco Use: _____ Quantity: _____ Alcohol Consumption: _____ounces per week

Marijuana Use: _____ Quantity: _____ Other: _____

Have you been under treatment for substance abuse? _____

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? _____

How often are your bowel movements? _____ Do your stools: sink _____ float _____

Constipation? _____ Diarrhea? _____ Blood in stool? _____Mucus in stool? _____

Pain when stooling? _____ Other concerns:_____

Emotional and Spiritual Health

What is your opinion of yourself? _____

Describe the most negative emotion you experience_____

When and where do you most often feel this emotion: _____

Describe the most positive emotion you experience_____

When and where do you most often feel this emotion: _____

Do you have a spiritual or religious practice? _____ Describe: _____

On a scale of 1 – 10 *(1 being the lesser, 10 the greater*) Please rate yourself in the following qualities

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? _____

_____

Describe your exercise routine (type, frequency) _____

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

One Year: _____

Reproductive Health History
Female Anatomy

Method of Contraception and length of use:

Pills: _____

Patch: _____

Diaphragm: _____

Injection: _____

Condoms: _____

IUD: _____

Abstinence: _____

Rhythm method: _____

Fertility Awareness: _____

Other: _____

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

Are you under treatment for fertility? _____ Describe current treatment(s) to date (IUI, IVF, etc.): _____

_____

Gynecological Provider: _____ Phone_____

Menstrual History

Age of Menses: _____ What was this like for you? _____

_____

Last Menstrual Period: _____ Length of Menses: _____ Length of Cycle: _____

Are you trying to conceive? Yes____ No ____ Possibility of Pregnancy_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced sexual trauma? Yes _____ No _____ Describe: _____

Did you undergo counseling for this? _____

Please review and check or circle the following:

Painful Periods	Past Present	Irregular cycles Early Late	Past Present
Heaviness in Pelvis prior to menses		Dark Thick Blood at: Beginning End Both	
Excessive Bleeding Pads per Hour		Headache or Migraine with menses	
Dizziness		Bloating	
Water Retention		Ovulation: Painful Failure to	
Endometriosis Location (if known)		Fibroids Location (if known)	
Uterine or Cervical Polyps		Uterine Infection(s)	
Vaginal Infection(s)		Cysts Location:	
Bladder Infection(s)		Urinary Incontinence	
Painful Intercourse		Vaginal Dryness	
Episodes of Amenorrhea How long?			

Pregnancy History

Number of Pregnancies: _____ Number of Births: _____ Premature Births: _____

Dates of Births: _____

Miscarriage(s): _____ Dates: _____ Termination(s): _____ Dates:_____

Spotting During Pregnancy: _____ Weak Newborns at Birth: _____ Incompetent Cervix: _____

Tearing: _____ Cesarean: _____ Episiotomy: _____ Vacuum or Forceps Assisted Birth: _____

Briefly describe your experience with:

Pregnancy: _____

Labor: _____

Birthing_____

Post-Partum: _____

Maternal Family History

Infertility _____ Fibroids _____ Endometriosis _____ PMS _____ Menopause_____

Cancer (type): _____

Menstrual Problems: _____

Other: _____

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

Your Birth Trauma (if known): _____

Other: _____

_____

_____

_____

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	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Any additional Information you would like to share with your practitioner: _____

_____

_____

_____