Confidential Intake Form

Date of Initial Visit:		**Date of Birth:**	
Name:		**Age:**	
Address:		**Home Phone:**	
County:		**Work Phone:**	
Post Code:		**Mobile Phone:**	
E-Mail Address:		**Occupation:**	
Marital/Relationship Status:		**Referred by:**	

Client Confidentiality Release Form

I understand that payment is due at the time of treatment unless arrangements have been made otherwise.

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 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 for 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 Signature: _____ **Date:** _____

Therapist/Practitioner Signature: _____ **Date:** _____

HIPAA regulations require that all practitioners should have a signed release form from their client before taking any notes about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Practitioners should have this form signed before taking any notes. Clients should receive a copy of the form they signed (upon request) and the practitioner maintains a copy for their records.

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:** _____

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

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

Signature: _____ **Date:** _____

Practitioner: DO NOT send this page with your case study report – for your records ONLY

Client Initials:		**Age:**	
Date of Visit:		**Practitioner Name:**	
Case Study Number:			

Reason For Visit

Primary reason for visit?		**When did you first notice it?**	
What bought it on?		**Describe any stressors occurring at the time:**	
What activities provide relief?		**What makes it worse?**	
Is this condition getting worse? **If yes, please provide details:**	**Yes** ☐ **No** ☐	**Does it interfere with work?** **If yes, please provide details:**	**Yes** ☐ **No** ☐
Sleep? **If yes, please provide details:**	**Yes** ☐ **No** ☐	**Recreation?** **If yes, please provide details:**	**Yes** ☐ **No** ☐
Have you had massage/bodywork before?	**Yes** ☐ **No** ☐	**If yes, what type?**	

Medical History

Are you currently under the care of another healthcare provider(s)?	**Yes** ☐ **No** ☐	**If yes, please give reason(s):**	
Name of Practitioner:		**Address:**	
Phone:		**E-Mail Address:**	
Current medications and/or supplements and remedies: **If yes, please state what you are on:**	**Yes** ☐ **No** ☐	**Any Allergies?** **If yes, please specify allergen and reaction:**	**Yes** ☐ **No** ☐
Any previous surgeries? **If yes, please list year and type of surgery and/or recent procedures:**	**Yes** ☐ **No** ☐	**Hospitalisations?** **If yes, then please list:**	**Yes** ☐ **No** ☐
Accidents or traumas? **If yes, then please list:**	**Yes** ☐ **No** ☐	**Falls/injuries to Sacrum/tailbone?** **If yes, then please give full details:**	**Yes** ☐ **No** ☐
Other?	**Yes** ☐ **No** ☐	**If yes, please provide details:**	

Please review and check the following:

	Past	Present		Past	Present
Headaches: **Type:**	☐	☐	**Pins and needles in arms, legs, hands or feet**	☐	☐
Asthma	☐	☐	**Spinal problems**	☐	☐
Cold hands or feet	☐	☐	**Anxiety**	☐	☐
Swollen ankles	☐	☐	**Depression**	☐	☐
Sinus conditions/frequent colds	☐	☐	**Sleep disturbance**	☐	☐
Seizures	☐	☐	**Fainting spells**	☐	☐
Loss of smell or taste	☐	☐	**Loss of memory**	☐	☐
Skin disorders: **Type:**	☐	☐	**Varicose veins and/or haemorrhoids**	☐	☐
Sciatica	☐	☐	**Muscular tension:** **Where?**	☐	☐
Painful/swollen joints	☐	☐	**Herniated/bulging discs**	☐	☐
High or low blood pressure	☐	☐	**Contact lenses**	☐	☐
Dentures/partials	☐	☐	**Artificial/missing limbs**	☐	☐
Other (not mentioned above):	☐	☐	**Do you use tobacco?** **If yes, please state quantity?**	**Yes** ☐ **No** ☐	
Alcohol? **If yes, quantity?**	**Yes** ☐ **No** ☐		**Marijuana?** **If yes, quantity?**	**Yes** ☐ **No** ☐	
Have you ever been under treatment for substance use?	**Yes** ☐ **No** ☐		**If yes, please give details:**		
Other?	**Yes** ☐ **No** ☐		**If yes, please provide details:**		

Family History

	Still Living?	Cause of Death/Age Of	Major Health Issues
Mother	Yes ☐ No ☐		
Father	Yes ☐ No ☐		
Siblings If yes, please give further details:	Yes ☐ No ☐		
Maternal Grandmother	Yes ☐ No ☐		
Maternal Grandfather	Yes ☐ No ☐		
Paternal Grandmother	Yes ☐ No ☐		
Paternal Grandfather	Yes ☐ No ☐		
Other?	Yes ☐ No ☐		

Digestion and Elimination

	ANSWER		ANSWER
Typical Breakfast:		Typical Lunch:	
Typical Dinner:		Snacks:	
Water intake (glasses/day):		Caffeine intake:	
What is the worst item in your diet?		What foods are your weakness?	
Are you subject to binge eating?	Yes ☐ No ☐	If you ticked yes for binge eating, what foods?	
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 suffer from constipation?	Yes ☐ No ☐	Do you have blood in your stools?	Yes ☐ No ☐
Do you have mucus in your stools?	Yes ☐ No ☐	Do you have pain when stooling?	Yes ☐ No ☐
Other concerns?	Yes ☐ No ☐	If yes, please provide details:	

	ANSWER		ANSWER
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 when you feel this?	
Do you pray or have a spiritual practice?	Yes ☐ No ☐	If yes, please provide details:	

On a scale of 1-10 (*1 being the lesser, 10 the greater)* Please rate yourself:

	ANSWER		ANSWER
Faith		Hope	
Charity		Generosity	
Sense of Humour		Sense of Fun	
Fear		Grief	
Other?	Yes ☐ No ☐	If yes, please describe briefly	
What hobbies or activities do you have that provide you with a sense of accomplishment?		Describe your exercise routine (type, frequency)	
What changes would you like to achieve in 6 months?		Changes in one year?	

Check and Describe symptoms as applicable:

	ANSWER		ANSWER
Headaches: **Migraine?** **Tension?** **Cluster?**	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	**If yes to any of these, please provide details:**	
Low back pain? **If, yes, details:**	Yes ☐ No ☐	**Sore heels?** **If yes, details:**	Yes ☐ No ☐
Varicose veins? **If yes, location?**	Yes ☐ No ☐	**Numbness in legs/feet?** **If yes, details:**	Yes ☐ No ☐
Family history of prostate disease? **If yes, type?**	Yes ☐ No ☐	**Relationship?**	
Family history of cancer? **If yes, type?**	Yes ☐ No ☐	**Relationship?**	
History of sexually transmitted disease? **If yes, when?** **Type?**	Yes ☐ No ☐	**Rate your interest in sex:** **High** **Moderate** **Low** **None**	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Do you ever have difficulty experiencing orgasms?	Yes ☐ No ☐	**Have you ever experienced a history of:** **Rape** **Trauma** **Incest**	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
If yes to any of these questions, when?		**Did you undergo counselling for this?** **What was this like for you?**	Yes ☐ No ☐

Urinary Symptoms (*describe as indicated*)

	ANSWER	ANSWER	
Painful urination? **If yes, details:**	**Yes** ☐ **No** ☐	**Frequent urination?** **If yes, details:**	**Yes** ☐ **No** ☐
Nocturnal urination/frequency? **If yes, details:**	**Yes** ☐ **No** ☐	**Bladder/kidney infections?** **If yes, details:**	**Yes** ☐ **No** ☐
Changes in urinary stream? **If yes, describe flow, stream, strength of stream:**	**Yes** ☐ **No** ☐	**When did you first notice these symptoms?** **Are they getting better or worse?** **If yes, describe:**	**Yes** ☐ **No** ☐

Erectile Function (*describe as indicated*)

	ANSWER	ANSWER	
Difficulty obtaining an erection?	**Yes** ☐ **No** ☐	**Difficulty maintaining an erection?**	**Yes** ☐ **No** ☐
Painful ejaculation? **If yes, describe:**	**Yes** ☐ **No** ☐	**Is there a history of back injury/trauma?** **If yes, describe:**	**Yes** ☐ **No** ☐
When did you first notice these symptoms? **Are they getting better or worse?** **If yes, describe:**	**Yes** ☐ **No** ☐	**Are you currently taking any medication(s) or supplements?** **If yes, please list:**	**Yes** ☐ **No** ☐
Results of PSA (Prostate Specific Antigen) test if known:		**Date of Test?**	
Results of sperm count (if applicable and known):		**Date of Test?**	
Additional comments:			