



TRADITIONAL MAYA MASSAGE

ARVIGO TECHNIQUE

CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Date of Initial Visit: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ email: _____

Date of Birth: _____ Age: _____ Occupation: _____

Referred by: _____ Have you had massage before?: _____

What type?: _____

REASON FOR VISIT

What is your primary concern: _____

What are other areas of concern?: _____

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? _____

Describe your exercise routine (type, frequency): _____

FAMILY HISTORY

Alive?	Age/Cause of Death	Major Health Issues
Mother:	_____	_____
Father:	_____	_____
Siblings:	_____	_____
Maternal Grandparents:	_____	_____
Paternal Grandparents:	_____	_____
Family History of Abuse _____	<i>Circle if applicable:</i>	physical emotional sexual spiritual

DIGESTION & ELIMINATION

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____

Water intake (glasses/day) _____ Caffeine _____

What foods are you 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 _____

Constipations? _____ Blood in stool? _____ Pain when stooling? _____

Other Conerns? _____

FOR MEN and WOMEN

CIRCLE any of the following you are *CURRENTLY* experiencing
UNDERLINE any of the following you have experienced in the *PAST*

Headaches (migraines, tension, cluster)			
Pins and needles in arms, legs, hands or feet			
Asthma			
Fainting spells			
Loss of smell or taste			
Loss of memory			
Skin disorders: Acne, Fungus, Psoriasis, other:_____			
Varicose veins			
High/ low blood pressure			
Muscular tightness_____			
Herniated or bulging disc (location)_____			

MEDICAL HISTORY

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

Reason(s)_____

Allergies: specify allergen and reaction:_____

Supplements/Remedies_____

Do you use Tobacco?_____Quantity_____Alcohol?_____quantity_____ounces/day

Have you been under treatment for substance use? If so, please describe_____

Surgical History (year and type)_____

Recent procedures_____

Hospitalizations_____

MALE ~ REPRODUCTIVE HEALTH HISTORY

Check and Describe *those symptoms as applicable*

Headaches: Migraine_____tension_____Cluster_____Low back pain_____

Sore heels_____Varicose Veins_____Location_____Numbness in legs/feet_____

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_____

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 you getting better or worse_____Describe_____

ERECTILE DYSFUNCTION (describe as indicated)

Difficulty obtaining an erection _____ Difficulty maintaining an erection _____ Painful ejaculation _____

Is there a history of back injury/trauma_____Describe_____

Current medications/supplements_____

Results of PSA (prostate specific antigen) Test if known_____Date done_____

Results of sperm count (if applicable and known)_____Date done_____

FEMALE ~REPRODUCTIVE HEALTH HISTORY

How many pregnancies have you had? _____ Number of deliveries _____

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 _____ Length of Menses _____

Episodes of Amenorrhea _____ when _____ For how long _____

Are you under the treatment for infertility _____ Describe current treatment to date: _____
IUI, IVF, etc) _____

Rate you 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 _____

Please circle as appropriate:

Painful Periods	Irregular
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
Sore heels when walking	Numb legs and feet when standing still
Low back ache	Painful Intercourse
Constipation	Endometriosis
Endometritis	
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	Difficult menopause
Dry vagina (without menopause)	Cysts (ovarian, breast)
Cancer (cervix, bladder, uterus, ovarian, bladder, bowel)	
Sexually transmitted diseases (date and type)_____	

MENOPAUSE (circle the symptoms that apply to you)

Hot flashes	Insomnia	Fatigue	Memory Loss
Mood swings	Irritability	Depression	Spotting (menses)
Dry Vagina	Flooding	Clotting	Irregular menses
Increased/Decreased Libido		Vaginal Discharge (describe):_____	

When did these symptoms begin_____

Are they getting worse_____ better_____ same_____ Last menstrual period_____

Are you on/or ever been on hormonal replacement therapy_____ if so, how long_____

Name and dose_____

Reason for stopping_____

Other medications/herbal remedies_____

Age of mother at menopause_____ Concerns/Experience_____

List of contraindications:

For Women:

- Not recommended for five days prior to the onset of menses, however a gentle stroking of the lower pelvis may be helpful.
- Not recommended during menstruation, but a gentle, light, superficial stroking over the lower pelvis can be used to reduce cramping
- IUD (intrauterine device) is present
- Pessary for organ prolapse must be removed prior to the massage
- If pain and discomfort do not diminish beyond the sixth treatment
- MAM is contraindicated in the first trimester of pregnancy
- Within the first six weeks following a normal vaginal delivery or the first three months after a caesarean section; postpartum massage should be done by a qualified midwife or physician.

For Men and Women:

- Not recommended for at least six weeks after any surgeries or until the physician says it is safe to resume normal activity
- Fever is present
- Cancer is present- may be considered safe if client has been in remission for a year or longer.
- Acute infection is present
- Hiatal Hernia (gentle massaged will be used instead)
- Abdominal Aneurysm

Please read and sign:

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 the 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 updated on my health.

I have read the list of contraindications and agree to make the practitioner aware if they are present or if/when they should arise.

Client Signature: _____ Date: _____

