

Arvigo Techniques of Maya Abdominal Therapy, Female Intake and Consent Form

Name _____ Date of Initial Visit _____

Address _____ State _____ Zip _____

Home Phone _____ Other 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? _____

Describe any stressors occurring at the time _____

What activities provide relief? _____ What makes it worse? _____

Is this condition getting worse? _____ Interferes 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? _____

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 _____

Surgical History (year and type) _____

Recent Procedures _____

Hospitalizations _____

Accidents or Traumas _____

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

Please circle any of the following you have now or underline any that you have had in the past

Nervous System

Shingles
Numbness / Tingling
Trigeminal Neuralgia
Bell's palsy
Sciatica
Pinched Nerve
Other _____

Musculoskeletal

Bone or Joint Disease
Tendonitis / Bursitis
Arthritis / Gout
Sprains / Strains
Spasms / Cramps Jaw Pain / TMJ
Lupus
Osteoporosis
Muscular Tightness (location) _____
Other _____

Skin

Allergies
Rashes
Athletes Foot
Herpes / Cold Sores
Fungus
Other _____

Circulatory

Heart Condition
Phlebitis / Varicose Veins
Blood Clots
High / Low Blood Pressure
Lymph edema
Thrombosis / Embolism
Other _____

Respiratory

Asthma
Emphysema
Allergies
Sinus Ailment
Other _____

Other

Cancer / Tumors
Kidney / Bladder Ailment
Diabetes
Drug / Alcohol / Caffeine / Tobacco
Chronic Fatigue
Chronic Pain
Sleep Disorders
Herniated or Bulging Disc (location) _____
History of disordered eating

Other

Migraines / Headaches
Inflammation / Swelling
Infection
Depression/ Anxiety
Cold hands or feet
Fever
Communicable Diseases _____
Contact Lenses – Hard / Soft

Do you use any of the following? Tobacco Alcohol Recreational Drugs Frequency? _____

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 _____

Method of Contraception (circle) pills (which type? _____) patch diaphragm injection
 condoms IUD abstinence rhythm method fertility awareness method other _____
 Length of time on synthetic contraception (Pill, Patch, HRT or Injection) _____
 Last Pap smear _____ Results (if known) _____ Any abnormal PAPs in the past? _____
 Last Menstrual period (date) _____ Length of Menses _____ Menses is usually: light moderate heavy
 With menses do you use (circle) pads tampons combination other Which type/brand? _____
 Episodes of Amenorrhea _____ When? _____ For how long? _____
 Age of Menarche _____ What was this like for you? _____
 Birth Trauma if known _____

Circle and Describe the symptoms that apply

- | | |
|---|--|
| Painful periods | Vaginitis |
| Dark/thick/brown blood at beginning or end of cycle | Cancer (cervix, bladder, uterus, ovarian, breast, bowel) |
| Headache or Migraine with period | Uncomfortable Intercourse |
| PMS/Depression with or before period | Painful Intercourse |
| Heaviness or pressure in lower pelvis with period | Painful Ovulation |
| Irregular (late or early) | Failure to Ovulate |
| Dizziness with period | PCOS (Polycystic Ovarian Syndrome) |
| Excessive bleeding (> one pad/hour) | Difficult menopause |
| Bloating/water retention with period | Varicose veins of leg |
| Endometriosis | Numb legs and feet when standing still |
| Uterine polyps | Tired weak legs |
| Cysts (ovarian, breast) | Sore heels when walking |
| Fibroids (size and location) _____ | Low back ache |
| Uterine infections | Constipation |
| Bladder infections | Premature deliveries |
| Frequent urination | Difficult pregnancy |
| Vaginal discharge (describe) _____ | Spotting with pregnancy |
| Vaginal yeast infections | "Incompetent" cervix |
| Pelvic Inflammation | Chronic miscarriages |
| Endometritis | Weak newborn infants |
| Dry vagina (without menopause) | |

Are you currently under treatment for infertility (or have you been in the past)? (If yes, please describe) _____

(IUI, IVF, Egg Donor? Please list dates) _____

History of sexually transmitted disease? _____ When? _____ Type _____

Gynecological Provider _____ Address _____ Phone _____

Are you currently sexually active? _____ Have you been sexually active in the past? _____

Rate your interest in sex (please circle) High Moderate Low None

Do you have difficulty experiencing orgasms? _____

Have you experienced a history of Rape? _____ Trauma? _____ Incest? _____ If so, when? _____

Did you undergo counseling for this? _____

Maternal Family History

Low Fertility Fibroids/Cysts Endometriosis Difficult Menopause PMS/Depression

Menstrual Problems Stillbirth Miscarriage Cancer (type) _____

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

Menopause (If applicable, please circle the symptoms that apply)

Hot Flashes	Insomnia	Depression	Change in Libido
Mood Swings	Irritability	Memory Loss	Flooding (heavy bleeds)
Dry Vagina	Irregular Menses	Clotting	Fatigue
Spotting			

Vaginal discharge (describe) _____

Other symptoms not listed above _____

When did these symptoms begin? _____

Are they getting Worse? _____ Better? _____ Same? . Last Menstrual Period _____

Have you used hormone replacement therapy (HRT)? _____ If so, how long? _____

Name and dose _____

Reason for stopping _____

Other medications/herbal remedies _____

Age of Mother at menopause _____ Concerns/Experience _____

Additional Comments _____

Digestion and Elimination

Do you follow a specific diet? _____

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Snacks _____ Water Intake (glasses/day) _____ Caffeine _____

Are you subject to binge eating? _____ What foods? _____

What foods are your weakness? _____ What time of day do you eat these 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 and 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? _____

Do you pray 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? _____

In one year? _____

Disclosure Statement and Consent Form

I understand that Sarah Lawrence, LMP (Ruby Moon Wellness) is not a doctor and that this work is not represented as a substitute for medical care. I have listed all my known medical conditions and will inform Sarah of any change in my health between massage sessions. I am also responsible for consulting a qualified primary care provider for any physical ailment(s) that I may have. I further understand that a massage practitioner neither diagnoses nor prescribes for illness, disease, or other medical, physical, or emotional disorders, nor performs any thrusting joint/spinal manipulations nor engages in any sexual activity during or under the pretense of a massage session.

I, the undersigned hereby authorize Sarah Lawrence, LMP (Ruby Moon Wellness) who is currently licensed in the State of Washington (Lic # MA00021717) to perform the following treatment procedures:

- **Acupressure:** Acupressure uses the fingers to skillfully press key points on the body. When these trigger points are pressed they release muscular tension, promote blood circulation, and assist the body's energy.
- **Aromatherapy:** The use of aromatic plants for medicinal and healing purposes. Essential Oils (volatile oils) are applied to the skin directly or mixed with carrier oil and then applied to the skin. Possible side effects of essential oils are headache or allergic reaction.
- **Dietary Advice:** Food and supplement advice based on nutritional and western medical herbal studies.
- **Herbal Remedies:** Medicinal plants that are used to help alleviate ailments of the body. As is the case with any medicine, not all remedies work for each person and some people may experience mild to severe side effects, which may include death, however this is very rare. It is also important to note that no herbs have been approved, by the FDA, as "medicine" in clinical trials and that herbal remedies are only approved under dietary supplements.
- **Massage:** Therapeutic massage addresses tension and holding patterns in muscles and connective tissue thereby helping to relieve pain, stress, tightness and restricted mobility of joints.
- **Pelvic Floor Release:** Massage, trigger point, and release work for the muscles that make up the pelvic bowl. This work is not internal pelvic floor work.
- **Arvigo Techniques of Maya Abdominal Therapy (Including Castor oil packs, uterine steams, and Rainforest Remedies herbal medicine):** Specific massage therapy and adjunct techniques for the abdomen, pelvis, sacrum, low back and hips that work to bring about correct positioning of organs that have shifted and now restrict the flow of blood, lymph, nerve & chi energy.
- **Prenatal Massage:** Therapeutic massage during pregnancy to address the specific changes and concerns of the pregnant body. Please notify the therapist if the pregnancy is considered high risk.

I recognize the potential risks and benefits of the procedures described above, including a potential for the aggravation of symptoms existing prior to treatment. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Sarah Lawrence, LMP (Ruby Moon Wellness) regarding the cure or improvement of my conditions. I understand and agree that I am receiving massage therapy entirely at my own risk. I hereby release Sarah Lawrence, LMP (Ruby Moon Wellness) from any and all liability which may occur in connection with the above-mentioned procedures. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.

I understand that if I cancel with less than 24 hours notice or do not show up for an appointment I will be billed 80% of the service(s) reserved.

I understand that under HIPPA law health care providers are required to protect the privacy of your PHI: "Protected Health Information" which includes your name, contact information, notation of each visit and health information. Knowing this, I authorize Sarah Lawrence, LMP to take notes about my health during sessions. A full document on HIPPA law will be available to you if you would like further information.

I have read and understood the above statements.

Client Signature (or Parent/Guardian)

Date