

# Ruby Moon Wellness

Seattle, WA (206) 356-1291  
www.rubymoonwellness.com



## Confidential Client Intake Form, Female

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) \_\_\_\_\_

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  
Dark/thick/brown blood at beginning or end of cycle  
Headache or Migraine with period  
PMS/Depression with or before period  
Heaviness or pressure in lower pelvis with period  
Irregular (late or early)  
Dizziness with period  
Excessive bleeding (> one pad/hour)  
Bloating/water retention with period  
Endometriosis  
Uterine polyps  
Cysts (ovarian, breast)  
Fibroids (size and location) \_\_\_\_\_  
Uterine infections  
Bladder infections  
Frequent urination  
Vaginal discharge (describe) \_\_\_\_\_  
Vaginal yeast infections  
Pelvic Inflammation  
Endometritis  
Dry vagina (without menopause)

Vaginitis  
Cancer (cervix, bladder, uterus, ovarian, breast, bowel)  
Uncomfortable Intercourse  
Painful Intercourse  
Painful Ovulation  
Failure to Ovulate  
PCOS (Polycystic Ovarian Syndrome)  
Difficult menopause  
Varicose veins of leg  
Numb legs and feet when standing still  
Tired weak legs  
Sore heels when walking  
Low back ache  
Constipation  
Premature deliveries  
Difficult pregnancy  
Spotting with pregnancy  
"Incompetent" cervix  
Chronic miscarriages  
Weak newborn infants

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**  
(Circle the symptoms that apply)

Hot Flashes  
Mood Swings  
Dry Vagina  
Spotting

Insomnia  
Irritability  
Irregular Menses

Depression  
Memory Loss  
Clotting

Change in Libido  
Flooding (heavy bleeds)  
Fatigue

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 the intent of the Arvigo Technique of Maya Abdominal Massage™ (ATMAM) is to improve the functioning of my organs and health and that any relief of symptoms is incidental to the treatment.

I understand that the standard process of ATMAM™ consists of multiple sessions over an extended period of months, but neither myself nor the Maya Practitioner is under any obligation to complete the sessions.

I understand that the work is not represented as a substitute for medical care, that I have listed all my known medical conditions and physical limitations and will inform the massage practitioner, in writing, of any change in my physical 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 understand that a massage practitioner must be aware of any and all existing physical conditions that I have in order to provide appropriate massage. 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 or spinal manipulations or adjustments.

By Washington State law, it is illegal to request or engage in any sexual activity during or under the pretense of a massage session. I understand that upon such action the massage session will be terminated and reported to the authorities.

I agree to be on time for my appointments and to accept financial responsibility for any appointments missed or cancelled without 24 hours notice.

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. 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