

Ruby Moon Wellness

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



Confidential Client Intake Form, Male

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 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? _____

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? _____

Male~ Reproductive Health History

(Circle and Describe the symptoms that apply)

Headaches (Migraine or Tension) _____ Varicose Veins (location) _____ Low back pain _____
Sore heels _____ Numbness in legs/feet _____ Depression _____ Anxiety _____ Irritability _____
Family History of Prostate Disease _____ Type _____ Relationship _____
Family History of Cancer _____ Type _____ Relationship _____
History of sexually transmitted disease _____ When? _____ Type _____
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? _____

Urinary Symptoms

(Circle and Describe the symptoms that apply)

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 they getting better or worse? _____ Describe _____

Erectile Function

(Circle and Describe the symptoms that apply)

Difficulty obtaining an erection _____ Difficulty maintaining an erection _____ Painful ejaculation _____
Is there a history of back injury/trauma? _____ Describe _____
When did you first notice these symptoms? _____
Are they getting better or worse? _____ Describe _____
Current Medications or Supplements _____

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