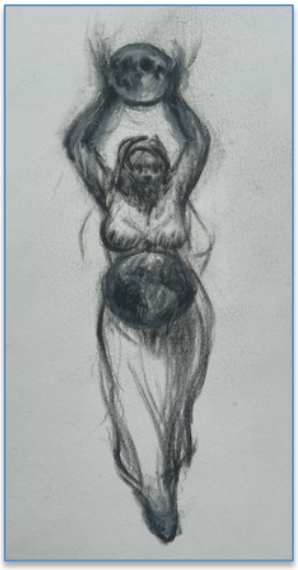
COASTSIDE HEALTH AND HEALING
CONFIDENTIAL CLIENT INTAKE FORM



Name_____

Date of Initial Visit_____

Address_____

State_____Zip_____

Home Phone_____ WorkPhone_____

Email _____

Date of Birth_____Age_____ Pronouns_____

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?_____

What brought it on?_____

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_____

DIGESTION & ELIMINATION

Typical Breakfast_____

Typical Lunch_____

Typical Dinner_____

Snacks_____ Water Intake(glasses/day) _____ Caffeine_____

What is the worse thing on your diet?_____ What foods are your weakness? _____

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

Do you experience bloating/gas/burps after eating?_____ Which 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 & 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?_____ Where are you?_____

Do you pray to 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_____

One Year_____

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_____

_____

Do you use Tobacco?____ Quantity_____/ppd Alcohol?_____Qty_____ounces/ day Marijuana?____Qty____Other:_____

Have you been under treatment for substance use? _____

If so, describe_____

Surgical History (year and type)_____

_____

Recent Procedures_____

Hospitalizations _____

_____

Accidents or Traumas_____

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

Birth Trauma if known _____

Circle any of the following you are currently experiencing and **<u>Underline</u>** any of the following you have experienced in the past:

Headaches (migraine, tension, cluster) Ringing in Ears Pins and needles in arms, legs, hands or feet Asthma Cold Hands or Feet Swollen ankles Sinus Conditions Seizures Loss of Smell or Taste Skin Disorders: Acne, Fungus, Psoriasis Other:_____

Sciatica Painful Joints Swollen Joints Spinal Problems Anxiety Fatigue Trouble Sleeping Fainting Spells Loss of Memory Depression

Muscular Tightness: (location) _____ Varicose Veins (location)_____

Herniated or Bulging disc: (location)_____High or Low Blood Pressure Contact lenses Dentures Artificial /Missing limbs Frequent Colds/ Upper Respiratory conditions

Circle any areas of issue below:

Painful periods Dark Thick Blood at Beginning or End of Cycle Headache or Migraine with period PMS/Depression with or before period Painful Ovulation Heaviness or pressure in lower pelvis with period Irregular (late or early) Dizziness with period Excessive Bleeding (> one pad/hour) Failure to Ovulate Bloating/water retention with period

UTERINE ~ REPRODUCTIVE HEALTH HISTORY

Age of Menarche_____ What was this like for you_____

How many Pregnancie(s) have you had?_____ Number of Deliverie(s)_____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 diaphram 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 period_____ Length of Menses_____

Episodes of Amenorrhea_____ When_____ For how long_____

Please circle as appropriate: Other Symptoms (Circle and Describe as indicated) Varicose veins of leg Numb legs and feet when standing still Low back ache Constipation Endometritis Fibroids (Size and Location if known)_____ Uterine infections Bladder infections Vaginitis Chronic miscarriages Weak newborn infants Incompetent cervix Pelvic Inflammation Dry vagina (without menopause) Cancer(cervix, bladder, uterus, ovarian, bladder, bowel) Frequent urination Vaginal discharge (describe) Vaginal Yeast infections Premature deliveries Difficult pregnancy Spotting with pregnancy Sexually Transmitted Disease (date and type)_____ Difficult menopause Cysts (ovarian breast) Tired weak legs Sore heels when walking Painful intercourse Endometriosis Uterine Polyps

Are you under the treatment for Infertility_____ Describe current treatment to date_____

(IUI, IVF,etc)_____

Gynecological Provider:_____Address_____Phone_____

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_____If so,-when_____

Did you undergo counseling for this_____

What was this like for you_____

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

MENOPAUSE

(Circle the symptoms that apply to you) Other symptoms not listed above_____

When did these symptoms begin_____ Are they getting worse_____better_____same_____Last Menstrual period_____

Are you on/ or ever been on hormone replacement therapy?_____if so, how long_____

Name and dose_____ Reason for stopping_____

Other medications/herbal remedies_____

Age of Mother at menopause_____Concerns/Experience_____

Additional Comments_____

PROSTATE ~ REPRODUCTIVE HEALTH HISTORY

Circle and Describe those symptoms as applicable Headaches: Migraine_____Tension_____Cluster_____

Low back pain Sore heels Varicose Veins _____Location_____

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_____

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_____If so,-when_____

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 they getting better or worse_____

Describe_____

Erectile Function(describe as indicated) 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:_____

_____

Results of PSA (prostate specific antigen) Test if known_____ Date done_____

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

Additional Comments _____

_____

_____

_____

_____

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 48 hours notice of cancellation of appointment otherwise full session fee will be owed. 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 of 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_____

Client Confidentiality Release Form

I, (name)_____

Address _____ Phone_____

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

Client Signature_____Date_____

Mail all intake forms to:
Samantha Corsiglia, Coastside Health and Healing, 751 Kelly Avenue, Half Moon Bay, CA 94019