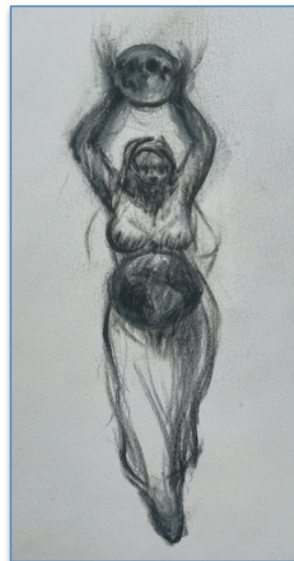


COASTSIDE HEALTH AND HEALING

CONFIDENTIAL CLIENT INTAKE FORM



Name _____

Date of Initial Visit _____

Address _____

State _____ Zip _____

Home Phone _____ WorkPhone _____

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? _____

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? _____ Quantitiy _____ ounces/ day

Marijuana? _____ Quantity _____ 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 Underline and 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 Mark Any areas of current persistent pain or tension on the figures 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 FEMALE ~ 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 Page

5 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 Memory Loss (describe): Spotting

(menses) Increased/Decreased Libido 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: Page 6 MALE ~ 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 other wise. I agree to give at least 48hours 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.

Signature: _____ Date: _____

Mail all intake forms to:

Samantha Corsiglia, Coastside Health and Healing, 751 Kelly Avenue, Half Moon Bay, CA 94019

