



The *Arvigo*
Techniques of Maya
Abdominal Therapy®

Confidential Intake Form

Date of Initial Visit: _____

Name: _____

Address _____

State _____ Zip _____ Home Phone _____

Work Phone _____ Cell _____ Email _____

Date of Birth _____ Age _____

Female _____ Male _____ Other _____ Preferred Pronoun _____

Occupation _____

Marital/Relationship status _____ Referred by _____

Consent for Treatment:

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I am aware that Mujo Wellness charges **50%** for day-of cancellations made up to **4 hours** before the scheduled appointment time. If I cancel **within that 4 hour window or don't show** for my scheduled appointment time, I will be charged **100%**. If I have to cancel for **any circumstances**, the above policy will be enforced. I agree that both cancellation and no-show fees will be paid within 24 hours of the appointment.

Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Practitioner signature _____ Date: _____

Reason for Visit

Primary reason for visit: _____

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? _____ **Interfere with work** _____ **sleep** _____ **recreation** _____

Have you had massage/bodywork before? _____

What type of pressure do you prefer (circle): **Light** **Medium** **Firm**

Do you light heat on the table (circle): **YES** **NO**

Medical History

Are you currently under the care of another health care provider(s)? _____ **Reason(s)** _____

Name of Provider: _____ **Address:** _____

Phone: _____ **Email:** _____

Current Medications and/or Supplements/Remedies: _____

Allergies: (specify allergen and reaction): _____

Surgical History (year and type) and/or Recent Procedures: _____

Hospitalizations: _____

Accidents or Traumas _____

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

Other: _____

Please review and check the following:

Headaches Type:	Past:	Present:	Numbness in feet or legs when standing	Past:	Present:
Asthma			Sore heels when walking		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Low Back Pain			Muscular Tension: Location:		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Herniated/Bulging Discs		
Painful/Swollen Joints			Artificial/Missing limbs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Cancer (type, past or current)		

Other (not mentioned above): _____

Family History

	Still Living?	Cause of Death and Age	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Digestion and Elimination

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

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

Do you use Tobacco? _____ Quantity _____ /ppd Alcohol? _____ Quantity _____ ounces/day

Marijuana? _____ Quantity _____ Other: _____ Have you been under treatment for substance use? _____

Food Allergies: _____

Do you experience bloating/gas/burps after eating? _____

What is the cause (stress, specific foods, time of day, etc.): _____

Are you subject to binge-eating: _____

How often are your bowel movements? _____ Constipation? _____

Diarrhea? _____ Pain when stooling? _____ Other: _____

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: _____

What are hobbies/activities that provide you with a sense of pleasure and accomplishment?

Describe your exercise routine (type, frequency): _____

Reproductive Health History - Female Anatomy

Last Pap smear _____ Results (if known) _____

Are you under the treatment for Infertility _____ Describe current treatment to date: _____

(IUI, IVF, etc.) _____

Gynecological Provider: _____ Address _____ Phone _____

Menstrual History Review:

Age of Menses: _____ What was this like for you? _____

Last Menstrual Period: _____ Length of Menses _____

Method of Contraception (circle) Pills Patch Diaphragm Injection Condoms IUD Abstinence

Rhythm Method Fertility Awareness Other: _____

Length of time using method: _____

Are you trying to conceive? _____ Possibility of Pregnancy _____

Painful Periods	Past	Present	Irregular cycles Early Late	Past	Present
	Heaviness in Pelvis prior to menses				Dark Thick Blood at: Beginning End Both
Excessive Bleeding Pads per Hour			Headache or Migraine with menses		
Dizziness			Bloating		
Water Retention			Ovulation: Painful Failure to		
Endometriosis Location (if known)			Fibroids Location (if known)		
Uterine or Cervical Polyps			Uterine Infection(s)		
Vaginal Infection(s)			Cysts Location:		
Bladder Infection(s)			Urinary Incontinence		
Painful Intercourse			Vaginal Dryness		
Episodes of Amenorrhea How long?					

Pregnancy History:

Number of Pregnancies: Number of Births: Dates:	Complications:	Miscarriages:	Terminations:
Premature Births:	Spotting during Pregnancy	Weak Newborns at Birth	Incompetent Cervix

Briefly describe your experience with:

Pregnancy: _____

Labor: _____

Birthing: _____

Post-Partum: _____

Maternal Family History (please circle): Infertility Fibroids Endometriosis PMS Menopause

Cancer (type) _____ **Menstrual Problems** _____ **Other** _____

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

Your Birth Trauma (if known): _____

Other:

Rate your interest in Sex: High _____ Moderate _____ Low _____ None _____

Do you have or ever had difficulty experiencing orgasms: _____

Do you have a history of rape: _____ **trauma:** _____ **incest:** _____ **If so, when:** _____

Did you undergo counseling for this? _____

What was this like for you _____

Please feel free to share any additional information: _____

Menopause

Age symptoms began: _____ Are they getting worse _____ better _____ same _____

Are you on/ or ever been on hormone replacement therapy? _____ if so, how long _____

Name and dose _____

Reason for stopping _____

Age of Mother at menopause: _____ Concerns/Experience _____

Check the following symptoms that apply to you:

Hot flashes	Insomnia	Fatigue	Memory Loss	Mood Swings
Vaginal Discharge	Dry Vagina	Depression	Anxiety	Irritability
Spotting	Flooding	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Please feel free to share any additional information: _____

Reproductive Health History - Male Anatomy

Please check the symptoms below that apply:

Painful Urination	Past	Present	Urinary Retention	Past	Present
Urinary Incontinence or Dribbling			Difficult starting or holding urine stream		
Weak or Interrupted Urine flow			Blood or pus in urine		
Pain or Burning with Urination			Pelvic pressure		
Nocturnal Urination How many times?			Insatiable sex drive		
Pain in lower back, esp. After intercourse			Pain or Discomfort Between scrotum and Testicles		
Pain or Discomfort in: Penis Testicles Rectum			Pain or Discomfort in Inner thighs: Left Right Both		
Frequent Bladder or Kidney Infections When?			Erection: Difficulty in Obtaining Maintaining Painful ejaculation		

Results of PSA (prostate specific antigen) Test if known _____ Date done _____

Results of Sperm count (if applicable and known) _____ Date done _____

Family History of Prostate Disease: Yes ___ No ___ Type _____ Relationship _____

Family History of Cancer Yes ___ No ___ Type _____ Relationship _____

Sexually transmitted disease Yes ___ No ___ Type if Known _____

Rate your interest in Sex: High _____ Moderate _____ Low _____ None _____

Do you have a history of rape _____ trauma _____ incest _____ If so, when? _____

Did you undergo counseling for this? _____

What was this like for you _____

Please feel free to share any additional information: _____