The Teal Center for Therapeutic Bodywork, Ltd.

CLIENT INFORMATION
Please print

Name____ Today's Date_______________________
Last First Middle

Address____

City________________________________State_______Zip__________E-mail___________________

Telephone (H) _____________________ (W) ______________________ (Cell) ______________________

Occupation____________________________ Birth Date __________ Referred by___________________

Emergency Contact: ____
Name Phone number

Would you like to receive e-mail notifications on promotional discounts/ newsletter? YES NO

****

Have you had professional bodywork before? _____ If so, what kinds? ______________________________

What are you looking for in your bodywork today? Relaxation_____Pain Relief_________
Injury Rehabilitation_____Other____

What are your primary areas of pain, discomfort or tension? ______________________________________

How long have you had this discomfort? ____

What do you think is the cause of this discomfort? ____

Have you had previous treatment for this discomfort? Yes_____ No_____If yes, please describe: ________

____

******

Are you presently under a doctor's or therapist's care? Yes _______ No _______

If so, for what? ______________________________ If we have questions, may we contact them? ______

Physician's or therapist's name____

Please list any medications you are taking and what they are for_____________________________________
____

Rate your normal stress level: 1(low) to 10 (high) _________Rate your current pain level: 1-10__________

Rate your general health: Excellent________ Good________ Fair________ Poor________

Do you have any allergies? __________If so, to what?____

Do you smoke? _____ Do you wear contact lenses? _____Do you take supplements? ______ If so, which ones? ____

What do you do for exercise, and how often? ____

(Females only) Are you pregnant? _________If so, when is your due date? ___________________
Have you had any complications? ____________Obstetrician's name: _____________________________

Please circle any of the following conditions which you currently have or have experienced within the last 6 months. Some may be contraindications for massage.

Systemic Infections: ___ Mononucleosis ___Flu ___Hepatitis ___Fever ___Other__________________

Cardiovascular: ___Varicose veins ___Stroke ___Acute inflammation
___Phlebitis ___High blood pressure ___Heart attack
___Blood clots ___Low blood pressure ___Heart disease

Skin infections: ____Eczema ____Burns ____Other____

Musculo-Skeletal: __Neck pain or stiffness __Low back pain __ Sports injuries: _______________
__Shoulder pain __Hip pain/sciatica __Fractures:____________________
__Upper back pain __Knee pain __Sprains/strains: ______________
__Arm pain __Leg pain __Torn ligaments/cartilage/tendons
__Hand pain __Foot pain __Whiplash
__Carpal tunnel __Scoliosis __Arthritis __ Fibromyalgia
__Other RSI: _______ __Osteoporosis __TMJ dysfunction/jaw pain
__Tension headaches __Migraines __Tinitis/ringing in ears

Neurological: __Disc disease __Numb, weak or cold extremities __Twitches/jumpiness
__Seizures __Chronic Fatigue Syndrome __Other______________

Endocrine: __Diabetes __Hypoglycemia __Other____________________________________

Respiratory: __Emphysema __Hay fever __Asthma __Other__________________________

Reproductive: (Females) __Menstrual cramps __PMS __Other___________________________
(Males) Prostatitis Other______________________________________

Digestive: __Constipation __Diarrhea __Colitis __Crohn's disease __Other__________

Psychiatric: __Mood swings __Sleep disorders/insomnia __Exhaustion __Depression
__Acute anxiety __Panic disorder __Other____________________________

Please describe any past surgeries, automobile accidents, serious falls, or other injuries and include dates if possible.
____
____

Please describe any diagnosis of cancer, including date of diagnosis and type of treatment.______________
____

Is there anything else I should know about you, your health, or your body before administering massage therapy? Please describe: ____

____

Signature____**Date**_______________

CONFIDENTIAL CLIENT INTAKE FORM
Additional Information for
Arvigo Techniques of Maya Abdominal Massage at The Teal Center

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. If there is anything you wish to bring to our attention, which is not asked on this form, please note it in the "Comments" section. Thank you

Name: ____ Date of Initial Visit.______________________________

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(glasses/day)________caffeine________

What is the worst thing on your diet?____________________________What foods are your weakness?___________________

Are you subject to binge eating? ____________What 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 eliminating?___________________

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_____________

FEMALE - REPRODUCTIVE HEALTH HISTORY

Age of Menarche_______What was this like for you____

How many Pregnancies have you had?_______________Number of Deliveries_____________Dates______________

Terminations___________When____

Miscarriages___________When____

Complications____

What was your experience of:

*Pregnancy*____

*Labor*____

*Delivery*____

*PostPartum*____

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 diaphragm 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 any of the following symptoms you have experienced:

Painful periods Irregular (late or early) Dark Thick Blood at Beginning or End of Cycle Dizziness with period

Headache or Migraine with period Excessive Bleeding (> one pad/hour) PMS/Depression with or before period

Failure to Ovulate Painful Ovulation Bloating/water retention with period Heaviness or pressure in lower pelvis with period

Other Symptoms (Circle and Describe as indicated)

Varicose veins of leg Tired weak legs Numb legs and feet when standing still Sore heels when walking

Low back ache Painful intercourse Constipation Endometriosis Endometritis Uterine Polyps

Fibroids (Size and Location if known)____

Uterine infections Frequent urination Bladder infections Vaginal discharge (describe) Vaginitis Vaginal Yeast infections

Chronic miscarriages Premature deliveries Weak newborn infants Difficult pregnancy Incompetent cervix

Spotting with pregnancy Pelvic Inflammation Sexually Transmitted Disease (date and type) ________________________

Dry vagina (without menopause) Difficult menopause Cancer(cervix, bladder, uterus, ovarian, bladder,bowel)

Cysts (ovarian breast)

Are you under 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,________________________________

MENOPAUSE *(Circle the symptoms that apply to you)*

Hot Flashes	Insomnia	Fatigue	Memory Loss
Mood Swings	Irritability	Vaginal Discharge (describe)______________________	
Dry Vagina	Fatigue	Depression	Spotting (Menses)
Flooding	Clotting	Irregular Menses	Increased/Decreased Libido

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:

The Teal Center for Therapeutic Bodywork, Ltd.

CLIENT AGREEMENT

HIPPA regulations require the following signed authorization:

I (name)________________________(address)________________________
give permission for my Teal Center practitioner to take notes about me, including health history/medical and/or personal information I choose to disclose. I understand that this information will be kept strictly confidential.

I also understand:

1. That massage therapy and/or acupuncture

   - is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow;

   - is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

2. That the massage therapists and/or acupuncturists

   - do not diagnose illness, disease or any other physical or mental disorder;

   - do not prescribe medical treatment or pharmaceuticals; and

   - do not perform any spinal manipulations.

3. That any and all of my appointment times are reserved exclusively for me and that I am responsible to remember them and to pay for appointments that I miss or cancel with less than 24 hours notice.

I authorize The Teal Center to charge my credit card on file for the full amount of any appointment missed or cancelled with less than 24 hours notice.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Name___________________________________

Signature________________________________ Date____________

Welcome! And thank you for choosing The Teal Center.

Please read and ***initial*** each of the following

POLICIES

______ Appointments missed, cancelled or rescheduled with less than 24 hours notice will be charged in full. To avoid being charged for a missed appointment, we invite you to send a friend or family member in your place. Also, if we can fill appointments that are missed, cancelled or rescheduled with less than 24 hours notice the client will not be charged. *It is your responsibility to remember your appointments.* Confirmation calls are made 36-48 hours prior to the scheduled appointment.

______The Teal Center and its practitioners abide by the ethical standards of practice established by their respective certification boards (NCBTMB and NCCAOM). All clients shall refrain from any behavior that sexualizes or appears to sexualize the client/therapist relationship. If such behavior occurs at any time, therapists are instructed to terminate the session; payment will be made in full by the client and the Teal Center reserves the right to prohibit the client from returning to the Teal Center.

______ If you have a cold or other contagious illness, please call us before your appointment so we can check with your therapist to see if it is appropriate for you to come in.

______ In order to preserve a peaceful environment, we ask that you silence your cell phones while at The Teal Center.

______Tips are appreciated but *never* expected. If you wish to leave a gratuity for your therapist we ask that you do so in cash or by check made directly to the therapist.

______ If you move or change phone numbers, it is your responsibility to inform us. This is important so we can reach you in case of any emergency or any necessary and unforeseen scheduling changes.

______ The Teal Center does not submit insurance claims. We are happy to provide you with medical receipts, any treatment notes and payment history for your personal records. We will communicate directly with your insurer *at their request only.*