Noreen Cerqua, LCMT

Confidential Intake Form for Women ♀

Date of Initial Visit: ___________________

Name: ____

Address: ____

State: _____________ Zip: ____________________ Email: ____

Home Phone: ____________________ Work Phone: _____________________ Cell Phone: _____________________

Date of Birth: ______________________ Age: ________ Occupation:______________________________________

Marital/Relationship status: ______________________ Referred by: ____

Client Confidentiality Release Form

I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
I agree to give at least 24hourse notice of cancellation of appointment.
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:____________________________

HIPAA regulations require all practitioners obtain a signed release form from their client before taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records.

Confidentiality of medical and personal information obtained during the course of the practitioner’s work is of the utmost importance. Failure to comply with these confidentiality regulations could result in penalties.

I, (name)____ of (address) ______________________________________

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 understand this information may be shared with the Arvigo Institute, LLC for statistical data collection only. All relevant identifying information will not be disclosed, such as name, address, ss number, date of birth.

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

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers.

Signature: ____ Date: ___________________________

Client Initials: ______________________________ Case Study #______________________

Date of Visit: ______________________________ Age: ________ Male_____ Female____

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? ______________________________________

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 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:____

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____

____

Please review and check the following:

Headaches Type:	Past Present	Pins and Needles in arms, legs, hands or feet	Past Present
Asthma		Spinal Problems	
Cold Hands or Feet		Anxiety	
Swollen ankles		Depression	
Sinus Conditions Frequent Colds		Sleep Disturbance	
Seizures		Fainting Spells	
Loss of Smell or Taste		Loss of Memory	
Skin Disorders Type:		Varicose Veins/Hemorrhoids Location:	
Sciatica		Muscular Tension Location:	
Painful/Swollen Joints		Herniated/Bulging Discs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Artifical/Missing Limbs	

Other (not mentioned above): ____

Do you use Tobacco? _________ Quantity: ________/ppd Alcohol?_________ Quantitiy: _________ounces/day

Marijuana? ________ Quantity: _______ Other:____

Have you been under treatment for substance use? ___________________

Family History

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

Digestion and Elimination

Typical Breakfast: ____

Typical Lunch: ____

Typical Dinner: ____

Snacks: _____________________________ Water Intake (glasses/day): ___________ Caffeine: ________________

What is the worst item in 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 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 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): _______________________________

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

____

Describe your exercise routine (type, frequency): ____

What changes would you like to achieve in 6 months? ____

____

One Year? ____

____

Female Reproductive Health History

When did you begin your menses? ________ What was this like for you? ______________________________________

How many pregnancy(s) have you had? ________ Number of Birth(s)? _________ Dates: ________________________

Termination(s)? _____________ When? ____

Miscarriage(s)? _____________ When? ____

Complications: ____

What was your experience of:

Pregnancy ____

*Labor*____

*Birthing*____

*Post Partum*____

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

Birth Trauma (if known): ____

Method of Contraception (circle):

pills *patch* *diaphragm* *injection* *condoms* *IUD* *abstinence* *rhythm method*

fertility awareness *Other:* ____________________________ Length of time using method:________________________

Last Pap Smear (date): ___________ Results (if known): ____

Date of Last Menstrual Period: ________ Length of Menses: ________ Are you Pregnant/Trying to Conceive?_________

Episodes of Amenorrhea? ______________ When? _____________ For how long? _____________________________

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? ____

Additional Comments: ____

____

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Please check as appropriate:

Painful Periods	Irregular Cycles (early or late)
Dark, thick blood at beginning of cycle	Dark, thick blood at the end of cycle
Headache or Migraine with Period	Dizziness with Period
Bloating/Water Retention with Period	Heaviness in Pelvis with Period
PMS/Depression with or Before Period	Excessive Bleeding (> one pad/hour)
Failure to Ovulate	Painful Ovulation
Varicose Veins	Tired Weak Legs
Numb Legs and Feet when standing	Sore Heels when walking
Low Back Ache	Painful Intercourse
Constipation	Endometriosis
Endometritis/Uterine Infections	Uterine Polyps
Fibroids	Vaginal Discharge/Vaginitis
Bladder Infections/Incontinence	Chronic Miscarriage
Weak Newborn Infants	Premature Deliveries
Incompetent Cervix	Spotting with Pregnancy
Pelvic Inflammation	Sexually Transmitted Disease
Dry Vagina	Difficult Menopause
Cancer, especially of reproductive area	Cysts, especially breast/ovarian
Other:	

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

Cancer (type): ______________ Menstrual Problems: _______________ Other: ___________________________________

Menopause

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

Are you on/or ever been on hormone replacement therapy? ______ If so, for 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
Decreased Libido	Disturbed Sleep Pattern			

Additional Comments:

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