



Noreen Cerqua, LCMT

**Confidential Intake Form for Men ♂**

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: \_\_\_\_\_

**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		Artificial/Missing Limbs	

Other (not mentioned above): \_\_\_\_\_

Do you use Tobacco? \_\_\_\_\_ Quantity: \_\_\_\_\_/ppd      Alcohol? \_\_\_\_\_ Quantity: \_\_\_\_\_ 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? \_\_\_\_\_  
\_\_\_\_\_

## Male Reproductive Health History

**Check and describe symptoms as applicable:**

Headaches: Migraine\_\_\_\_ Tension\_\_\_\_ Cluster\_\_\_\_ Low back pain\_\_\_\_ Sore heels\_\_\_\_

Numbness in legs/feet \_\_\_\_ Varicose Veins \_\_\_\_ Location: \_\_\_\_\_

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? \_\_\_\_\_

**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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_