Gen-Touch Massage & Holistic Therapy

Locations: San Diego & Solana Beach
619.865.6619

CONFIDENTIAL
MALE - FERTILITY
CLIENT HOLISTIC HEALTH INTAKE FORM

Name: _____Date of Initial Visit: _____

Address: _____State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: ____/____/____ Age: _____ Occupation: _____

Marital Status: □ Single □ Married □ Divorced. If married, how long? _____

Have you ever had massage/bodywork before? □ Yes □ No If yes, what type: _____

Referred by: _____

REASON FOR VISIT

What is your primary concern? _____

What are other areas of concern? _____

When did you 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? _____

Describe your exercise routine (type, frequency): _____

FAMILY HEALTH HISTORY

	Still Living? Y or N	Age	If Deceased, Cause and Age of Death	Major Health Issues
Mother				
Father				
Siblings				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				
Paternal Grandmother				

FAMILY HISTORY

Family History of Abuse or Extreme Conditioning? Check if applicable: □ physical □ emotional □ sexual □ spiritual. If any checked, please briefly describe:_____
_____
_____
Family History of Substance Abuse _____ Suicide _____
Other Trauma _____

EMOTIONAL & SPIRITUAL

What is your opinion of yourself? _____
If possible, please describe the most positive emotion you experience: _____
When do you most often feel this emotion? _____
If possible, please describe the most negative emotion you experience: _____
When do you most often feel this emotion? _____
Where are you emotionally? _____
How good are you about expressing your emotions? □ Great □ Good □ Fair □ Not So Good
How do you deal with stress? _____
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 _____Anger: _____ Guilt: _____
Other (describe briefly): _____
What are your hobbies/activities that provide you with a sense of pleasure and accomplishment?
_____
What changes would you like to achieve in 6 months? _____
Changes in one year? _____

DIGESTION & ELIMINATION

Typical Breakfast: _____
Typical Lunch: _____
Typical Dinner: _____
Snacks: _____Water Intake: _____ (glasses/day) Caffeine: _____

DIGESTION & ELIMINATION (Continued)

Do you eat organic foods? □ Yes □ No. If yes, which foods?_____
What is the worst thing on your diet? _____
What foods are your weakness? _____
Are you subject to binge eating? □ Yes □ No. If yes, what foods? _____
Do you experience bloating/gas/burps after eating? □ Yes □ No. If yes, what foods trigger this?
_____
How often are your bowel movements? _____ Do your stools: □ sink □ float
Do you have any of the following issues: Constipation? □ Yes □ No. If yes, how often?_____
Blood in stool? □ Yes □ No. If yes, how often?_____ Mucus in stool? □ Yes □ No. If yes, how often?_____ Pain when stooling? □ Yes □ No. If yes, how often?_____ Do you have any of the following digestive or elimination issues? Please circle all that apply, currently and underline all that apply in the past:

IBS (Irritable Bowel Syndrome)	Acid Reflux	Diverticulitis
Small amounts of food = feel full	Gastritis	Diarrhea
Chronic Indigestion or Heartburn	Crohn's Disease	Vomit after meals
Multiple Food Allergies	Celiac Disease	Ulcerative Colitis

Other concerns with digestion or elimination: _____
_____
_____

MEDICAL HISTORY

Are you currently under care of another health care provider(s)? □ Yes □ No.
Reason(s): _____
Name(s) of Practitioner: _____
Address: _____
Phone: _____ Email: _____
Current Medications: _____
Allergies (specify allergen and reaction): _____
Supplements/Remedies: _____
_____
Do you use Tobacco? □ Yes □ No. If yes, quantity: _____ pack/day. Alcohol? □ Yes □ No.
If yes, quantity: _____ounces/bottles/glasses/day. Marijuana? □ Yes □ No. If yes, quantity _____ Other Substances: □ Yes □ No. If yes, □ Currently? □ Past?
What kind? _____ Quantity: _____Frequency: per day/week/month.
Have you been under treatment for substance abuse? □ Yes □ No. If yes, describe: _____
_____
Surgical History (year and type): _____
Recent Procedures: _____
Hospitalizations: _____
Accidents or Traumas: _____
Falls/Injuries to sacrum/head/tailbone (describe) _____
Birth Trauma, if known: _____

MEDICAL HISTORY (Continued)

CIRCLE any of the following you are CURRENTLY experiencing
UNDERLINE any of the following you have experienced in the PAST

Headaches (migraine, tension, cluster) Ring in the Ears

Pins and Needles in arms, hands and/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 Depression Fatigue

Trouble Sleeping Fainting Spells Loss of Memory High or Low Blood Pressure

Muscular Tightness (location):_____Varicose Veins (location): _____

Herniated or Bulging disc (location): _____ Contact Lenses Dentures

Artificial/Missing Limbs Frequent Colds/Upper Respiratory conditions

Describe any other current persistent pain or tension or any other conditions you may have below:
_____
_____
_____

MALE – REPRODUCTIVE HEALTH HISTORY
(Check and Describe those symptoms as **applicable**)

Headaches: □ Migraine □ Tension □ Cluster □ Low back pain □ Sore heels
□ Varicose Veins, Location:_____

Family History of Prostate Disease : □Yes □ No. If yes, type :_____
Relationship of family member with the disease: _____

Family History of Cancer: □Yes □ No. If yes, type :_____
Relationship of family member with cancer: _____

History of sexually transmitted disease: □Yes □ No. If yes, when: _____
Type? :_____Were you treated?: □Yes □ No. If yes, method used/medication taken?: _____

Rate your interest in Sex: □ High □ Moderate □ Low □ None
Do you have or ever had difficulty experiencing orgasms? □ Never □ Sometimes
□ Frequently □ Always. Additional comments:_____
Have you experienced a history of the following? □ rape □ incest □ molestation. If so, when:
_____
Did you undergo counseling for this? _____

What was counseling like for you? _____

Urinary Symptoms: (circle those applicable)

Painful urination Bladder/Kidney Infection(s)
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 worse?:_____ If so, describe: _____

Erectile Dysfunction (circle those applicable and describe as indicated)

Is there a history of back injury/trauma?: _____ Describe: _____
When did you first notice these symptoms?:_____
Are they getting worse?:_____ If so, describe: _____
Current Medications or Supplements: _____
Results of PSA (prostate specific antigen): Test, if known: _____ Date tested: _____

Fertility Challenges:
Have you had your sperm tested? □ Yes □ No. If yes, please provide date and results:
Count?_____ Motility? _____ Morphology? _____
Are they getting better worse?:_____ If so, describe: _____
Are you getting any type of medical or alternative (ie. Acupuncture or herbs) treatment? If yes, what kind?_____
Current Medications or Supplements: _____
Any surgeries related to reproductive organs or pelvic area or lower back? □ Yes □ No. If yes, please provide date and type of surgery: _____

ADDITIONAL COMMENTS:

Please read and sign:

I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
I agree to give at least 24 hours notice of cancellation of appointment. Cases of extreme emergency are considered exceptions to this cancellation policy.
I understand the treatment is not a replacement for medical care.
I understand the 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 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 treatment 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 practitioner updated on my health.
Client signature: _____ Date: _____
Practitioner signature: _____ Date: _____

Client Confidentiality Release Form

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. The practitioner does not sell or release your personal information for use outside our clinic. Your e-mail will be used solely to communicate clinic-related information to you. You may request to be removed from our e-mail list at any time.

I, (name)_____ Address_____
Phone _____ E-mail_____
give my permission, for my practitioner, Genevieve Siegel, to take notes about me, including health history/medical and/or personal information I choose to disclose to her.

I also understand that this information may 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:_____