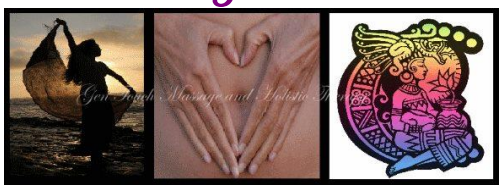
Gen-Touch Massage & Holistic Therapy



Locations: San Diego & Solana Beach
619.865.6619

CONFIDENTIAL
FEMALE (TEENAGE)
CLIENT HOLISTIC HEALTH INTAKE FORM

Name: _____Date of Initial Visit: _____

Address: _____ City: _____ State: _____ Zip: _____

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

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

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 _____

MATERNAL HISTORY

Medications your mother took when she was pregnant with you (if any)? _____
_____
Maternal Family History of (check if appropriate) □ Infertility □ Fibroids □ Endometriosis □ PMS □ Cancer (type): _____ □ Other Menstrual Problems (type):_____
□ Menopausal Symptoms (type):_____
Age of Mother at menopause: _____Concerns/Experience: _____

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 emotionally? _____
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 _____ Sense of Joy _____ Fear/Anxiety _____ Grief _____
Anger: _____ Guilt: _____Worry: _____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: _____
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
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?_____ Other concerns with digestion or elimination (circle below):

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

MEDICAL HISTORY

Are you currently under care of another health care provider(s)? □ Yes □ No.
Reason(s): _____
Name(s) of Practioner: _____
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 and Frequency _____per day/week/month
Have ever done recreational drugs? □ Yes □ No. If yes, how long ago? _____
How often? _____ What type of drugs? _____
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) Ringing in the Ears Low Energy

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

Frequent Colds/Upper Respiratory conditions Weakness in Arms and Legs

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

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

FEMALE – REPRODUCTIVE HEALTH HISTORY

Age of Menarche: _____What was this like for you? _____
Date of your last Menstrual period: _____ Length of Menses: _____
Episodes of Amenorrhea □ Yes □ No. If yes, when? _____For how long? _____
Date of Last Pap Smear: _____Results (if known): _____
Method of Contraception (check current method(s) and underline past) □ pills □ patch
□ diaphragm □ injection □ condoms □ IUD □ abstinence □ rhythm method □ Other _____
Length of synthetic contraception (pill, patch, injection): _____

Please circle current issues and underline past, as appropriate:

Painful periods
Dark thick blood at beginning or end of cycle
Headache or migraine with period
PMS/Depression with or before period
Painful ovulation
Heaviness or pressure in lower pelvis with period
Irregular (late or early)
Dizziness with period
Excessive bleeding (> one pad/hour)
Failure to ovulate
Bloating/water retention with period

FEMALE – REPRODUCTIVE HEALTH HISTORY (continued)

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 aches	Constipation (with menses)
Endometriosis	Endometritis
Uterine Polyps	Polycystic Ovarian Syndrome (PCOS)
Adenomyosis	Uterine Infections
Frequent urination	Dry vagina
Bladder Infections	Vaginitis
Vaginal Yeast Infections	Pelvic Inflammation

Other reproductive issues (please specify):_____
Cysts (describe): _____
Fibroids (Size and location, if known):_____
Vaginal Discharge – Other than normal white or clear (describe):_____
_____
Have you ever had sexual relations? □ Yes □ No. If yes, age what age did you begin? _____
Is intercourse painful? ? □ Yes □ No. Sexually Transmitted Disease (date and type): _____
_____
Have you ever been pregnant? □ Yes □ No. If yes, number of deliveries? _____
Dates of Deliveries:_____
Terminations: □ Yes □ No. If yes, when? _____
Miscarriage(s) □ Yes □ No. If yes, when? _____
Gynecological Provider:_____
Address: _____Phone: _____
Have you experienced a history of trauma? □ Yes □ No. Rape? □ Yes □ No. Incest? □ Yes □ No. Molestation_□ Yes □ No. If so, when?_____
Did you report this to any authorities or tell anyone about this? □ Yes □ No. If yes, to whom did you tell? _____
Did you undergo counseling for this? □ Yes □ No. If yes, when and for how long? _____
_____
What was counseling like for you? _____
_____

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 or I may be charged a cancellation fee. 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: _____
Legal guardian 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:_____
Legal guardian signature: _____ Date: _____