



Full Circle Holistic- A Women's Health-Care Practice
7410 New LaGrange Rd. Ste. 207 Louisville, KY 40222 (502) 774-0460

The Arvigo Techniques of Maya Abdominal Therapy™ Confidential Intake

Date of Initial Visit _____

Name: _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Work Phone _____ Cell _____ email _____

Date of Birth _____ Age _____ Occupation _____

Marital/Relationship status _____ Referred by _____

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 /orSupplements/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) _____

Please review and check the following:

Headaches Type:	Past	Present	Numbness in feet or legs when star	Past	Present
Asthma			Sore heels when walking		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Low Back Pain			Muscular Tension: Location:		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Herniated/Bulging Discs		
Painful/Swollen Joints			Artificial/Missing limbs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Cancer (past or current) Type		

Other:

Family History

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

Gastrointestinal Health History

Describe your typical:
 Breakfast: _____
 Lunch: _____
 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? _____
 Food Allergies? _____ Describe _____
 How often are your bowel movements? _____ Do your stools: sink _____ float _____
 Constipation? _____ Blood in stool? _____ Mucus in stool? _____ Pain when stooling? _____
 Diarrhea? _____ Other? _____

Lifestyle, Emotional & Spiritual

What is your opinion of yourself? _____

Describe the most positive emotion you experience _____

When and Where do you experience this emotion? _____

Describe the most negative emotion you experience _____

When and Where do you experience this emotion? _____

Describe your Spiritual and/or Religious practice: _____

On a scale of 1 – 10 (1 being the lesser, 10 the greater) Please rate yourself in each of these qualities:

Faith _____ Hope _____ Charity _____ Generosity _____ Sense of Humor _____ Fear _____ Grief _____ Sense of Fun _____

What hobbies/ activities provide you with pleasure and accomplishment _____

Describe your exercise routine (type, frequency) _____

What changes would you like to achieve in 6 months: _____

One Year: _____

Do you use Tobacco? _____ Quantity _____ /ppd Alcohol? _____ Quantity _____ ounces/ day

Marijuana? _____ Quantity _____ Other: _____ Have you been under treatment for substance use? _____

Female Reproductive Health History

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method

Fertility Awareness Other: _____ Length of time using method _____ Last Pap smear _____ Results _____

Are now or in the past experiencing Fertility Challenges? Yes ___ No ___ Describe your treatment : _____

(IUI, IVF, etc) _____

Menstrual History Review and check as indicated:

Age of Menses: _____ What was this like for you? _____

Last Menstrual Period: _____ Length of Menses _____

Are you trying to Conceive? Yes _____ No _____ Are you Pregnant? Yes _____ No _____ Unsure _____

Painful Periods	Past	Present	Irregular cycles Early Late	Past	Present
	Heaviness in Pelvis prior to menses				Dark Thick Blood at: Beginning End Both
Excessive Bleeding Pads per Hour			Headache or Migraine with menses		
Dizziness			Bloating		
Water Retention			Ovulation: Painful Failure to		
Endometriosis Location (if known)			Fibroids Location (if known)		
Uterine or Cervical Polyps			Uterine Infection(s)		
Vaginal Infection(s)			Cysts Location:		
Bladder Infection(s)			Urinary Incontinence		
Painful Intercourse			Vaginal Dryness		
Episodes of Amenorrhea How long?					

Rate your interest in Sex: High _____ Moderate _____ Low _____ None _____

Do you have or ever had difficulty experiencing orgasms _____

Have you experienced trauma? Yes ___ No ___ Describe _____

Did you undergo counseling for this? _____

What was this like for you? _____

Pregnancy History

Number of Pregnancies: _____ Dates _____ Miscarriage(s) _____ Dates _____ Termination(s) _____ Dates: _____

Number of Births: _____ Dates: _____

Complications for any of the above, describe: _____

Premature Births? _____ Spotting During Pregnancy? _____ Weak Newborns? _____ Incompetent Cervix? _____

Describe your experience with:

Pregnancy: _____

Labor: _____

Birth: _____

Post Partum: _____

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

Cancer (type) _____ Menstrual Problems _____ Other _____

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

Your Birth Trauma (if known) _____

Menopause

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

Are you on/ or ever been on hormone replacement therapy? _____ if so, 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
Spotting	Flooding	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Additional Information you feel important your practitioner should know that is not mentioned here: