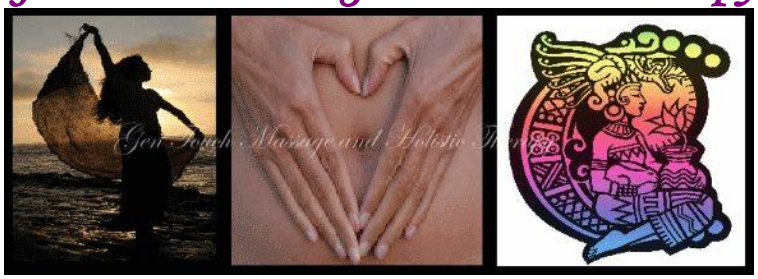
Gen-Touch Massage & Holistic Therapy



Locations: San Diego & Solana Beach
619.865.6619

CONFIDENTIAL
FEMALE
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: _____

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 _____

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 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? _____
Do you pray or have a spiritual practice? _____
On a scale of 1- 10 (1 being the lesser, 10 the greater), please rate yourself on the below:
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?_____ 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 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 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:
_____
_____
_____

FEMALE – REPRODUCTIVE HEALTH HISTORY

Age of Menarche: _____What was this like for you? _____
Date of your last Menstrual period: _____ Length of Menses: _____
What is a typical menses for you?

	Flow: Heavy=H Medium=M Light=L	Color: Brown=B Dark Red=DR Bright Red=BR	Clots or Tissue? Clots = C Tissue = T What size?	Pain or Discomfort? Level of Pain or Discomfort 1 = Very Mild to 10 = Intense Location of the Discomfort?
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
Day 7				

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): _____

FEMALE – REPRODUCTIVE HEALTH HISTORY (continued)

How many Pregnancies have you had? _____ Number of Deliveries? _____
Dates of Deliveries:_____
Terminations: □ Yes □ No. If yes, when? _____
Miscarriage(s) □ Yes □ No. If yes, when? _____
Complications? _____
What was your experience of Pregnancy? _____
Labor? _____
Delivery? _____
Post Partum? _____

Please circle 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

Other symptoms (Circle and describe as indicated):

Varicose Veins of leg
Numb legs and feet when standing still
Low back aches
Constipation
Endometritis
Polycystic Ovarian Syndrome (PCOS)
Uterine Infections
Bladder Infections
Vaginal Yeast Infections
Premature Deliveries
Difficult pregnancy
Spotting with pregnancy
Dry vagina (without menopause)
Tired weak legs
Sore heels when walking
Painful intercourse
Endometriosis
Uterine Polyps
Adenomyosis
Frequent urination
Vaginitis
Chronic miscarriages
Weak newborn infants
Incompetent cervix
Pelvic Inflammation
Difficult menopause

Other reproductive issues (please specify):_____
Sexually Transmitted Disease (date and type):_____
Cysts (describe): _____
Fibroids (Size and location, if known):_____
Vaginal Discharge (describe): _____
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? _____
What was counseling like for you? _____
Are you under the treatment for Fertility(IUI, IVF, etc.)? □ Yes □ No. If yes, please complete the Fertility intake form.

MENOPAUSE (Circle the symptoms that apply to you)

Hot flashes	Insomnia	Fatigue	Memory Loss
Mood Swings	Irritability	Vaginal discharge (describe): ________________________	
Dry Vagina	Fatigue	Depression	Spotting (menses)
Flooding	Clotting	Irregular menses	Increased/Decreased Libido

Other symptoms not listed above: ____

When did these symptoms begin? ____

Are they getting worse? ☐ Yes ☐ No. Better? ☐ Yes ☐ No. Same ☐ Yes ☐ No.

Last Menstrual period: ____

Are you on/ or ever been on hormone replacement therapy? ☐ Yes ☐ No.

If so, how long? ____

Name and dose of HRT: ____

If stopped, reason for stopping: ____

Other medications/herbal remedies: ____

Additional comments about menopause: ____

____

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: _____
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:_____