Gen-Touch Massage & Holistic Therapy

Locations: San Diego & Solana Beach
619.865.6619

CONFIDENTIAL
MINOR 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: ________________________________

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   AnxietyDepression   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
Numb legs and feet when standing still
Low back aches
Endometriosis
Uterine Polyps
Adenomyosis
Frequent urination
Bladder Infections
Vaginal Yeast Infections
Tired weak legs
Sore heels when walking
Constipation (with menses)
Endometritis
Polycystic Ovarian Syndrome (PCOS)
Uterine Infections
Dry vagina
Vaginitis
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:

____
____
____
____
____
____
____
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____

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: __________________

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