

Make yourself a cup of tea.
Find a quiet and calm place to sit.
This is a time for you recenter and
check in with yourself.

*Thank yourself for making the time
to take care of you.*





Confidential Intake Form

Name: _____ Date of Initial Visit: ___ / ___ / ___
Date of Birth: ___ / ___ / ___ Age: _____ Preferred Pronouns: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Phone: (___) ___ - _____ Work: (___) ___ - _____ Cell: (___) ___ - _____
Email: _____ Occupation: _____
Marital/Relationship Status: _____ Referred by: _____

Client Confidentiality and Confidentiality Release

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under their professional scope of practice. As such, the practitioner does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the practitioner updated on my health. Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client before taking any information about them. The practitioner maintains a copy for their records, and clients may also request a copy of the form they signed.

I, (Print Name) _____
give my permission for my practitioner, to take notes including health history/medical and/or personal information I choose to disclose to them. I understand this information may be used for the purpose of practitioner certification and/or may be shared with the Arvigo Institute, LLC for statistical data collection only. All relevant identifying information will not be disclosed, such as name, address, and date of birth.

Client Signature: _____ Date: ___ / ___ / ___

Practitioner Signature: _____ Date: ___ / ___ / ___

2nd Practitioner Signature: _____ Date: ___ / ___ / ___

Reason for Visit

Primary reason for visit: _____

When did your first notice it? _____

What idea do you have about what brought it on? _____

Describe any stressors occurring at the time: _____

What activities provide relief? _____

What makes it worse? _____

Is this condition getting worse? _____

Does it 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 of Practitioner: _____ Phone: (____) ____ - _____

Name of Practitioner: _____ Phone: (____) ____ - _____

Current Medications, Supplements, Herbal Remedies: _____

Allergen and your Allergic Reactions: _____

Surgical History (include cosmetic surgeries) Year and Type: _____

Hospitalizations: _____

Accidents or Traumas: _____

Falls/Injuries to Sacrum/Head/Tailbone (describe): _____

General Health

Which of these have you experienced?

Past	Present		Past	Present	
<input type="radio"/>	<input type="radio"/>	Headaches <i>Type/Location:</i> _____	<input type="radio"/>	<input type="radio"/>	Skin Disorders <i>Type:</i> _____
<input type="radio"/>	<input type="radio"/>	Muscular Tension <i>Location:</i> _____	<input type="radio"/>	<input type="radio"/>	Varicose Veins <i>Location:</i> _____
<input type="radio"/>	<input type="radio"/>	Numbness in feet or legs	<input type="radio"/>	<input type="radio"/>	Herniated/Bulging Discs
<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Painful/Swollen Joints
<input type="radio"/>	<input type="radio"/>	Sore heels when walking	<input type="radio"/>	<input type="radio"/>	Artificial/Missing limbs
<input type="radio"/>	<input type="radio"/>	Cold Hands or feet	<input type="radio"/>	<input type="radio"/>	Low Back Pain
<input type="radio"/>	<input type="radio"/>	Anxiety	<input type="radio"/>	<input type="radio"/>	Fainting Spells
<input type="radio"/>	<input type="radio"/>	Swollen ankles	<input type="radio"/>	<input type="radio"/>	High or Low Blood Pressure (circle)
<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Seizures
<input type="radio"/>	<input type="radio"/>	Sinus Conditions	<input type="radio"/>	<input type="radio"/>	Cancer
<input type="radio"/>	<input type="radio"/>	Frequent Colds			<i>Type:</i> _____
<input type="radio"/>	<input type="radio"/>	Trouble falling asleep			<i>Past Treatment:</i> _____
<input type="radio"/>	<input type="radio"/>	Trouble staying asleep			<i>Current Treatment:</i> _____
<input type="radio"/>	<input type="radio"/>	Hemorrhoids			

Known Biological Family Medical History

Start two generations back and include siblings.

	Relation to you	Still Living?	Cause of Death	Age	Major Health Issues
1					
2					
3					
4					
5					
6					
7					

Food Diary

Please log your food intake for three days prior to you appointment.

DAY ONE

Breakfast:

Lunch:

Dinner

Snacks:

Beverages:

DAY TWO

Breakfast:

Lunch:

Dinner

Snacks:

Beverages:

DAY THREE

Breakfast:

Lunch:

Dinner

Snacks:

Beverages:

Digestive Health

What dietary restrictions do you have? _____

Water Intake (glasses per day): _____ Caffeine (type/amount): _____

Are you subject to binge eating? _____ What foods? _____

Do you experience burps, bloating, or gas after eating? (circle) _____ What foods trigger this? _____

Do you use Tobacco? ____ How much / How often? _____

Alcohol? ____ How much / How often? _____

Marijuana? ____ How much / How often? _____ Other: _____

Have you been treated for substance use? _____

How often are your bowel movements? _____

Do your stools: Sink ____ Float ____ Constipation? ____ Diarrhea? ____

Blood in stool ? ____ Mucus in stool? ____ Pain when stooling? ____ Other _____

Emotional & Spiritual Health

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? _____

Do you pray or have a spiritual practice? _____

If so, what do you pray to? _____

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 ____ Other (describe briefly) _____

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? _____

Reproductive Health

Please fill out all that applies to you.

Are you trying to conceive? _____ Are you possibly pregnant? _____

Are you being treated for difficulty becoming pregnant? _____

Describe treatment(s) to date (IUI, IVF, etc) : _____

Method of Contraception (circle) : Pills Patch Injection Diaphragm Condoms

IUD Abstinence Pulling out Fertility Awareness (Charting)

Other: _____ Length of time using method: _____

Last Pap smear: _____ Results: _____

Menstruation

Age of first period: _____ What was this like for you? _____

Last start date of period: _____ Length of monthly cycle : _____

	Past	Present		Past	Present
Painful Periods	<input type="radio"/>	<input type="radio"/>	Uterine or Cervical Polyps	<input type="radio"/>	<input type="radio"/>
Irregular cycles: <i>Early</i> ___ <i>Late</i> ___	<input type="radio"/>	<input type="radio"/>	Fibroids <i>Location (if known):</i> _____	<input type="radio"/>	<input type="radio"/>
Heavy Pelvis before Menses	<input type="radio"/>	<input type="radio"/>	Uterine Infection(s)	<input type="radio"/>	<input type="radio"/>
Dark Thick Blood (circle): <i>Beginning End Both</i>	<input type="radio"/>	<input type="radio"/>	Missed periods <i>How long?</i> _____	<input type="radio"/>	<input type="radio"/>
Excessive Bleeding <i>Pads/Hour:</i> _____	<input type="radio"/>	<input type="radio"/>	Cysts <i>Location (if known):</i> _____	<input type="radio"/>	<input type="radio"/>
Headache or Migraine w/ menses	<input type="radio"/>	<input type="radio"/>	Bladder Infection(s)	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	Vaginal/Genital Infection(s)	<input type="radio"/>	<input type="radio"/>
Bloating	<input type="radio"/>	<input type="radio"/>	Urinary Incontinence	<input type="radio"/>	<input type="radio"/>
Water Retention	<input type="radio"/>	<input type="radio"/>	Painful Intercourse	<input type="radio"/>	<input type="radio"/>
Painful Ovulation	<input type="radio"/>	<input type="radio"/>	Vaginal/Genital Dryness	<input type="radio"/>	<input type="radio"/>
No Ovulation	<input type="radio"/>	<input type="radio"/>	Sexually Transmitted Disease <i>Type:</i> _____	<input type="radio"/>	<input type="radio"/>
Endometriosis <i>Location (if known) :</i> _____	<input type="radio"/>	<input type="radio"/>			

Pregnancy History

Current Pregnancy: Due Date: _____ Doctor/Midwife: _____

Home/Hospital/Birthing Center: _____

Total number of pregnancies: ____ Number of births: ____ Dates: _____

Briefly describe your experience with:

Pregnancy: _____

Labor: _____

Birthing: _____

Postpartum: _____

Complications: ____ Miscarriages: ____ Terminations: ____ Premature births: _____

Spotting during pregnancy: ____ Weak newborn at birth: ____ Incompetent cervix : ____

Maternal Family History of (please circle):

Cancer (type): _____ Hysterectomy Other: _____

Medications you may have been exposed to in utero (if any): _____

Did you have any trauma at birth? (if known) : _____

Menopause

Do you experience any of the below?

Hot flashes	<input type="radio"/>	Dry Vagina/Genitals	<input type="radio"/>
Insomnia	<input type="radio"/>	Depression	<input type="radio"/>
Fatigue	<input type="radio"/>	Anxiety	<input type="radio"/>
Memory Loss	<input type="radio"/>	Irritability	<input type="radio"/>
Mood Swings	<input type="radio"/>	Spotting	<input type="radio"/>
Vaginal/Genital Discharge	<input type="radio"/>	Flooding	<input type="radio"/>
		<i>Pads/Hr:</i> _____	

Age symptoms began: ____ Are they getting worse? ____ Better ____ Same _____

Are you on or have you ever been on hormone replacement therapy? _____ How long? _____

Name and dose: _____

Reason for stopping: _____

Age of biological mother at menopause: ____ Concerns/Experience: _____

Sexual wellbeing - please fill out to your comfort level

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

Do you have or did you ever have difficulty experiencing orgasms? _____

Do you have a history of: Rape ____ Trauma ____ Incest ____

If so, when? _____ Did you undergo counseling for this? _____

Did you find counseling helpful? _____

Pelvic and Genital Issues and Pain

Pain or Discomfort in (circle) :

Penis Testicles Perineum Rectum Urinary Tract Labia Vagina Clitoris

Pain or Discomfort in groin or inner thighs (circle) : Left Right Both

Frequent infection in: UTIs ____ Bladder ____ Kidney ____ When? _____

Difficulty with arousal or erection (circle) :

Obtaining Maintaining Painful Painful ejaculation

Urinary Difficulty (circle) : Difficult starting Weak flow Interupted flow Painful Urination

Urinary Retention Bedwetting Nocturnal Urination (Times per night?): _____

Do you have any sexually transmitted disease(s)? _____

Do you experience pelvic pressure? _____ Pain in lower back, esp after intercourse? _____

Family History of Prostate Disease: Yes ____ No ____ Type: _____ Relationship to you: _____

Results of PSA (Prostate Specific Antigen) Test if known: _____ Date : _____

Results of Sperm Analysis : Count : ____ Motility : ____ Morphology : ____ Date done: _____

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



Business Policy

Please read and sign below.

Mission:

Our mission is to serve those who seek our guidance with compassion and dedication to the health of our planet. We utilize traditional healing techniques and contemporary medical knowledge in order to help our clientele navigate their health.

Please familiarize yourself with my business policies so that we may provide you with the best experience possible.

Cancellations:

Wildflowers Wellness has a 48 hr cancellation policy. Non-emergency cancellations will be charged the full amount for the appointment. If you have a contagious disease, please notify the office before the appointment and we will determine the best plan of action.

Late arrivals:

Late arrivals are charged the full amount for the appointment.

Billing:

Payment is due at time of service. An initial visit is typically 2 hours long and costs \$400. Follow up visits are 1.5 hours long and cost \$300. When subsequent sessions are longer or shorter, the hourly rate is \$200 per hour, billed in 15 minute increments.

Please initial to agree to the following:

_____ I understand that I am not to do the uterine portion of the self-care massage if I have an IUD, may be pregnant, or during my period.

_____ I agree that the self-care massage is for my self-care only, not to be performed on others.

Breast massage will not be performed without prior written consent.

_____ Initial if you give consent to breast massage.

I understand that nutritional and herbal supplements provided by Wildflowers Wellness are to be used under Wildflowers practitioner care, and are refillable through the Wildflowers Wellness office only.

Print Name _____ Email _____

Signature _____ Date _____