

**Confidential Intake Form**

Date of Initial Visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female \_\_\_\_\_\_\_\_ Male\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_ Preferred Pronoun\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital/Relationship status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Confidentiality and Release Form**

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 his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations (unless specified under his/her professional scope of practice). 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 therapist/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 best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

I, (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

give my permission, for my practitioner, to take notes including health history/ medical and /or personal information I choose to disclose to him/her. 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, social security number, date of birth.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Reason For Visit

**Primary reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did your first notice it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What brought it n? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 /or Supplements/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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other:**

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**Please review and check the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Headaches**  **Type:** | **Past Present** | **Numbness in feet or legs when standing** | **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 (not mentioned above):**

# Family History

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Still Living?** | **Cause of Death/age of** | **Major Health Issues** |
| **Mother** |  |  |  |
| **Father** |  |  |  |
| **Siblings** |  |  |  |
| **Maternal**  **Grandmother** |  |  |  |
| **Maternal**  **Grandfather** |  |  |  |
| **Paternal**  **Grandfather** |  |  |  |
| **Paternal**  **Grandmother** |  |  |  |

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### Digestion and Elimination

**Typical Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Typical Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Typical Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Water Intake (glasses/day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Caffeine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use Tobacco? \_\_\_\_\_\_ Quantity\_\_\_\_\_/ppd Alcohol? \_\_\_\_\_\_ Quantity \_\_\_\_\_\_ounces/day**

**Marijuana? \_\_\_\_\_\_\_Quantity \_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you been under treatment for substance use?**

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often are your bowel movements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do your stools: sink \_\_\_\_\_\_ float \_\_\_\_\_\_\_**

**Constipation? \_\_\_\_\_\_\_\_\_\_Blood in stool? \_\_\_\_\_\_\_\_\_Mucus in stool? \_\_\_\_\_\_\_\_\_\_\_\_Pain when stooling? \_\_\_\_\_\_\_**

**Other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you pray to 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 \_\_\_\_\_\_\_\_\_\_\_\_\_Fear \_\_\_\_\_\_\_\_\_Grief \_\_\_\_\_\_\_\_ Other (describe briefly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are hobbies/ activities that provide you with a sense of pleasure and accomplishment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe your exercise routine (type, frequency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What changes would you like to achieve in 6 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**One Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Fertility Awareness Other: \_\_\_\_\_\_\_\_\_\_\_\_\_Length of time using method\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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|  |
| --- |
| **Reproductive Health History - Female Anatomy** |

**Last Pap smear \_\_\_\_\_\_\_\_\_\_\_ Results (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you under the treatment for Infertility \_\_\_\_\_\_\_\_\_\_\_\_\_Describe current treatment to date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(IUI, IVF, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gynecological Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Possibility of Pregnancy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **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?** |  |  |  |

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**Pregnancy History:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Number of Pregnancies:**  **Number of Births:**  **Dates:** | **Complications:** | **Miscarriages:** | **Terminations:** |
| **Premature Births:** | **Spotting during Pregnancy** | **Weak Newborns at Birth** | **Incompetent Cervix** |

**Briefly describe your experience with:**

**Pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Labor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birthing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other:**

**Rate your interest in Sex: High\_\_\_\_\_\_\_\_\_Moderate\_\_\_\_\_\_\_\_\_\_Low\_\_\_\_\_\_\_\_\_\_\_\_\_\_None\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have or ever had difficulty experiencing orgasms\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a history of rape \_\_\_\_\_\_\_trauma \_\_\_\_\_\_\_incest \_\_\_\_If so,-when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Did you undergo counseling for this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What was this like for you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please feel free to share any additional information:**

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##### **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:

|  |
| --- |
| **Reproductive Health History - Male Anatomy** |

**Please check the symptoms below that apply**

|  |  |  |  |
| --- | --- | --- | --- |
| **Painful Urination** | **Past Present** | **Urinary Retention** | **Past Present** |
| **Urinary Incontinence or**  **Dribbling** |  | **Difficult starting or**  **holding urine stream** |  |
| **Weak or Interrupted**  **Urine flow** |  | **Blood or pus in urine** |  |
| **Pain or Burning with**  **Urination** |  | **Pelvic pressure** |  |
| **Nocturnal Urination**  **How many times?** |  | **Insatiable sex drive** |  |
| **Pain in lower back, esp.**  **After intercourse** |  | **Pain or Discomfort**  **Between scrotum and**  **Testicles** |  |
| **Pain or Discomfort in:**  **Penis**  **Testicles**  **Rectum** |  | **Pain or Discomfort in**  **Inner thighs:**  **Left**  **Right**  **Both** |  |
| **Frequent Bladder or**  **Kidney Infections**  **When?** |  | **Erection:**  **Difficulty in Obtaining**  **Maintaining**  **Painful ejaculation** |  |

**Results of PSA (prostate specific antigen) Test if known\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date done\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Results of Sperm count (if applicable and known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date done\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History of Prostate Disease: Yes\_\_\_No\_\_\_Type\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History of Cancer Yes\_\_\_\_No\_\_\_\_\_\_Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sexually transmitted disease Yes \_\_\_No \_\_\_Type if Known\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rate your interest in Sex: High\_\_\_\_\_\_\_\_\_\_\_Moderate\_\_\_\_\_\_\_\_\_\_\_\_Low\_\_\_\_\_\_\_\_\_\_\_\_None\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a history of rape \_\_\_\_\_\_\_trauma \_\_\_\_\_\_\_incest \_\_\_\_\_\_\_\_ If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Did you undergo counseling for this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What was this like for you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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