Armonía Health LLC www.armoniahealth.com

Arvigo Maya Abdominal Therapy® & Chinese Medicine Confidential Intake Form Female

Name:____ Date of Initial visit: ________________

Address____

State______Zip_____________ Best phone to reach you __________________ 2nd best phone __________

Email ____ Can Armonía Health LLC add you to its email list? YES NO

Date of Birth____________________Age_________ Occupation____________________________________

Marital/Relationship status____________________ Referred by ____________________________________

Client Confidentiality & Consent to Treat Form

I understand my session with the practitioner, Li-Lan Hsiang Weiss, Licensed acupuncturist, 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 she perform spinal manipulations. The diagnosis that I may receive is from a Chinese medicine perspective and/or an assessment based on her Arvigo Maya Abdominal Therapy® training and may or may not correlate with a medical diagnosis I already have. 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 to the best of my understanding and take it upon myself to keep the practitioner updated on my health.

My session may involve one or more of the following therapies: acupuncture, Arvigo® Maya abdominal massage, guasha, glass cupping, moxabustion, energetic and spiritual healing. Take home recommendations and a follow up treatment plan shall be presented to me by the end of my initial session. The practitioner encourages open dialogue and will do her best to answer any questions I may have. I shall do my best to be an active participant in my own healing process. I fully understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that complications may result from acupuncture treatment. Among these possible complications are: bruising, fainting, numbness, weakness, nausea, hematoma, infection, burns, pain and discomfort, pneumothorax, and aggravation of present symptoms. I am fully aware that the acupuncture needles are sterile and disposable and that no needle used to treat me has ever been used on another person. I understand that acupuncture and Chinese medicine are not a substitute for standard Western medicine, that certain health disorders may require allopathic diagnosis and treatment, and that I am free to seek allopathic medical advice and treatment at any time, either in lieu of, or concurrently with acupuncture treatment.

HIPAA regulations require all practitioners obtain a signed release form from their patient/client before taking any information about them. Clients should receive a copy of the form they signed (upon request) and the practitioner maintains a copy for their records. I give my permission, for my practitioner, to take notes including health history/ medical and /or personal information I choose to disclose to him/her if he/she deems necessary. I understand this information may be shared under legal obligations or with another medical professional or health care provider to enhance my quality of care.

Cancellation policy: Our office prefers **48 hours** notice if you need to cancel or change your appointment; less than 24 hours notice of cancellation may incur a missed appointment fee of 50% of the session rate. We appreciate your consideration.
Current session rates, payable in cash, check, or credit card to Armonía Health LLC upon service are:

Initial Arvigo® session (2 hr): $150
Initial Fertility session (2 hr): $150
Follow Arvigo & acupuncture (75-90 min): $100
Initial session during pregnancy (75 min): $100
Initial acupuncture and consultation (90 min): $100
Follow up acupuncture: $80 for 60 min, $100 for 90 min

ClientSignature: ____ Date: ______________________

Printed name: ____

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:____

____

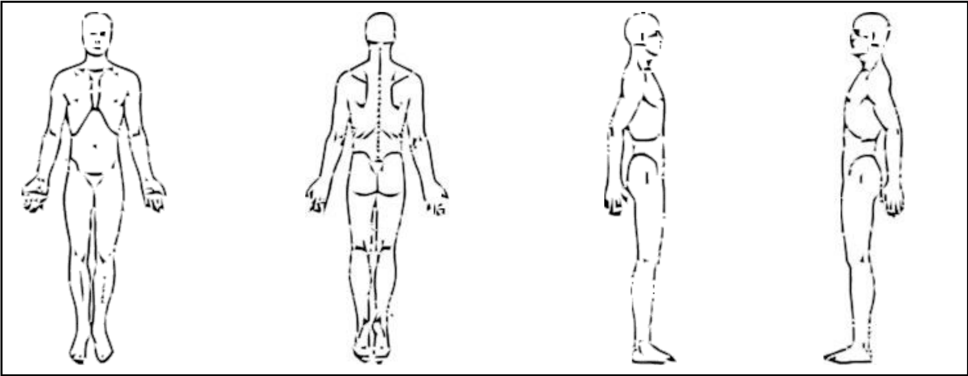
Hospitalizations: ____

Accidents or Traumas____

Falls/Injuries to Sacrum/head/tailbone (describe)____

Other:

Current and/or past areas of pain or discomfort



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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		Artifical/Missing limbs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Cancer (past or current) Type	

Family History

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

Gastroinstestinal 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?______Quantitiy______ounces/ day

Marijuana?_______Quantity______Other:__________________ Have you been under treatment for substance use?

Male Reproductive Health History

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 trauma: describe ____

Did you undergo counseling for this ____

What was this like for you ____

Additional Comments:

Chinese Medicine Symptom Checklist

Name:_______________________________________ Date:___________________

Please check any of the following symptoms you experience <u>frequently or have a tendency towards.</u>

___Fatigue/Low Energy
___Bruise easily
___Tired after eating
___Low appetite
___Strong appetite
___Loose stools
___Constipation
___Abdominal bloating
___Heartburn/Reflux
___Post Nasal Drip
___Nausea/Vomiting
___Frequent hiccups or belching
___Flatulence
abnormalities
___Hemorrhoids
___Excessive vaginal discharge
___Bad breath
___Tendency to worry/obsess
___Stomach ulcers
___Mouth sores
___Bleeding gums

___Recurrent colds/Infections
___Sinus problems
___Allergies
___Sweat easily
___Do not sweat
___Blood or mucus in stool
___Pain in the teeth or gums
___Skin problems
___Shortness of breath
___People often ask you to speak up
___Feel Sad

___Difficulty sleeping
___Heart palpitations
___Anxiety
___Memory problems
___Sores on the tongue
___Startle easily
___Laugh inappropriately

___Frequent irritability/Frustration
___Depression/Tendency to feel sad
___Frequent sighing
___Abdominal pain

___Pain under the ribcage
___Floaters
___Can’t see well at night
___Red eyes
___Wake between 1-3am
___Trouble falling asleep
___Dizziness
___Tight muscles
___Painful periods
___Irregular periods
___Inability to cry

___Low back pain
___Frequent urination
___Knee pain
___Low sex drive
___High sex drive
___Erectile dysfunction
___Night sweats
___Hot flashes
___Poor hearing
___Ringing in ear
___Wear socks to bed
___Vaginal dryness
___Congenital