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 Techniques of 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 in general. Among these possible complications are: bruising, fainting, numbness, weakness, nausea, hematoma, infection, burns, pain and discomfort, aggravation of present symptoms, and very rarely pneumothorax 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. Armonia Health LLC works with an integrative model, so my file can be shared if I see another practitioner at this practice.

Our office requires **48 hours** notice if you need to cancel or change your individual appointment with Li-Lan; less than 24 hours notice of cancellation will incur a charge of 60% of the individual session fee. We appreciate your consideration and respect with this matter. Current session rates, payable in cash, check, or credit card to Armonía Health LLC upon service are:

Initial Arvigo® session (2 hr): $150 Follow Arvigo & acupuncture (90 min): $100

Initial individual acupuncture with consultation (75 min): $100 Community acupuncture (1 hr): $55 initial, $40-60 follow up

Follow up acupuncture: $80 for 60 min, $100 for 90 min

ClientSignature: _____ Date: _____

Printed name: _____

Reason For Visit

Primary reason(s) for visit:_____

If there is a particular condition, 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 bodywork, acupuncture, energy work 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:_____

_____

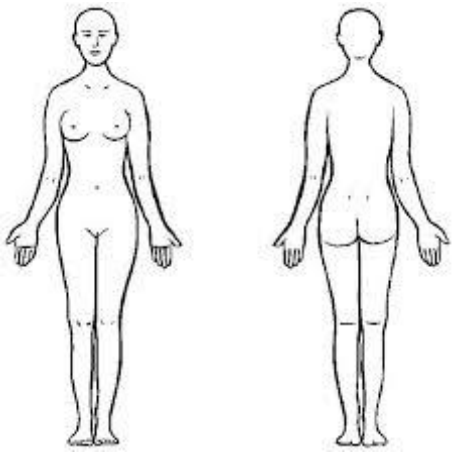
Hospitalizations: _____

Accidents or Traumas_____

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

_____

Current and/or past areas of pain or discomfort



Page 2. 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			Artifical/Missing limbs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Cancer (past or current) Type		

Other (not mentioned above)

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?_____ **Constipation?**_____

Blood in stool ?_____**Mucus in stool?**_____**Pain when stooling?**_____

Know food sensitivities: _____

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, have a spiritual practice, or meditate? _____

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:_____

Do you have experience receiving energy work? _____ **Would you like to know more about it?** _____

Female Reproductive Health History

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

Fertility Awareness Other:_____ **Length of time using method**_____

Last Pap smear_____**Results (if known)**_____

Are you under the treatment for fertility challenges?_____**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?			

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_____

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

Chinese Medicine Symptom Checklist

Name:_____ Date:_____

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

Spleen/Stomach Energy System

___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
___Hemorrhoids
___Excessive vaginal discharge
___Bad breath
___Tendency to worry/obsess
___Stomach ulcers
___Mouth sores
___Bleeding gums

Lung/Large Intestine Energy System

___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

Heart/Small Intestine Energy System

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

Liver/Gallbladder Energy System

___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

Kidney/Bladder Energy System

___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 abnormalities