



Armonía Health LLC www.armoniahealth.com

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

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 60% charge 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 acupuncture with consultation (75 min): \$100

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

Community acupuncture (1 hr): \$55 initial, \$40-60 follow up

Client Signature: _____ 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: _____

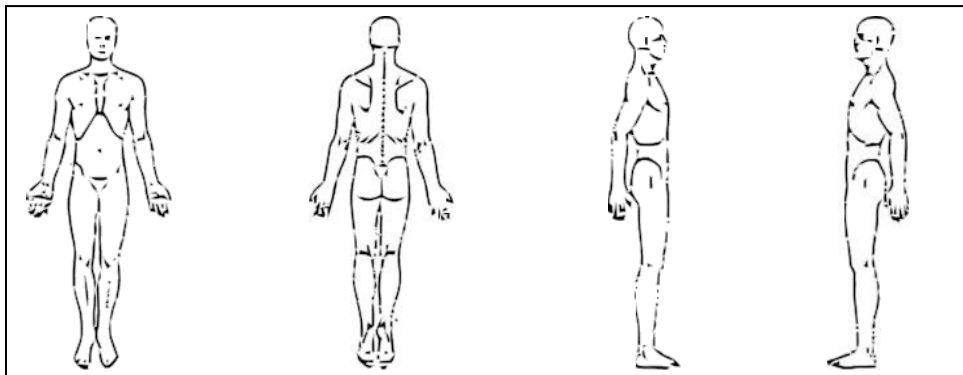
Hospitalizations: _____

Accidents or Traumas _____

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

Other:

Current and/or past areas of pain or discomfort



Please review and check the following:

	Past	Present		Past	Present
Headaches Type:			Numbness in feet or legs when star		
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		

Family History

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

Gastrointestinal 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? _____ Quantity _____ ounces/ day

Marijuana? _____ Quantity _____ Other: _____ Have you been under treatment for substance use?

Male Reproductive Health History

Please check the symptoms below that apply

	Past	Present	Urinary Retention	Past	Present
Painful Urination					
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 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