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 are payable in cash, check, or credit card to Armonía Health LLC on the day of service. Refer to our website, call our office and/or consult our online calendar for our rates.

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:_____

_____

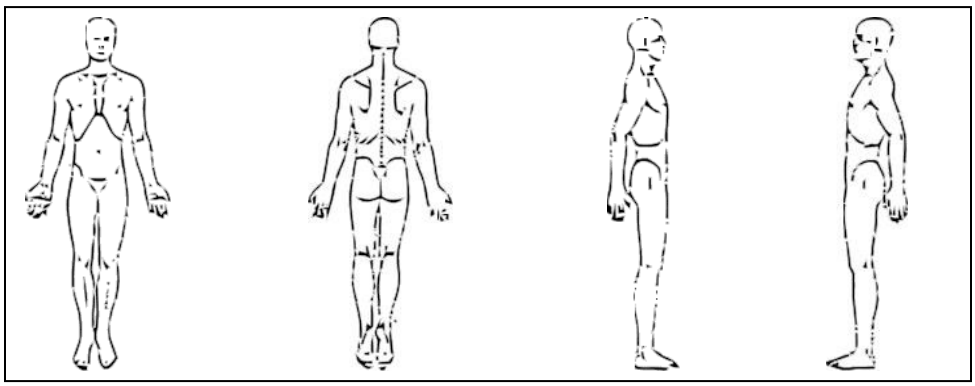
Hospitalizations: _____

Accidents or Traumas_____

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

Other:

Current and/or past areas of pain or discomfort



. **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 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