Make yourself a cup of tea.
Find a quiet and calm place to sit.
This is a time for you recenter and check in with yourself.

Thank yourself for making the time to take care of you.

WildFlowers

HOLISTIC CARE BASED IN THE MAYA TRADITION

Confidential Intake Form

Name: _____ Date of Initial Visit: ___ /___ /___

Date of Birth: ___ /___ /___ Age: _____ Preferred Pronouns: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: (___) ___ - _____ Work: (___) ___ - _____ Cell: (___) ___ - _____

Email: _____ Occupation: _____

Marital/Relationship Status: _____ Referred by: _____

Client Confidentiality and Confidentiality Release

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 their professional scope of practice. As such, the practitioner does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. 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 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 practitioner maintains a copy for their records, and clients may also request a copy of the form they signed.

I, (Print Name) _____

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

Client Signature: _____ Date: ___ /___ /___

Practitioner Signature: _____ Date: ___ /___ /___

2nd Practitioner Signature: _____ Date: ___ /___ /___

Reason for Visit

Primary reason for visit: _____

When did your first notice it? _____

What idea do you have about what brought it on? _____

Describe any stressors occurring at the time: _____

What activities provide relief? _____

What makes it worse? _____

Is this condition getting worse? _____

Does it 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 of Practitioner: _____ Phone: (___) ____ - _____

Name of Practitioner: _____ Phone: (___) ____ - _____

Current Medications, Supplements, Herbal Remedies: _____

_____

_____

Allergen and your Allergic Reactions: _____

Surgical History (include cosmetic surgeries) Year and Type: _____

_____

Hospitalizations: _____

Accidents or Traumas: _____

Falls/Injuries to Sacrum/Head/Tailbone (describe): _____

General Health

Which of these have you experienced?

Past	Present		Past	Present	
○	○	Headaches *Type/Location:* _____	○	○	Skin Disorders *Type:* _____
○	○	Muscular Tension *Location*: _____	○	○	Varicose Veins *Location*: _____
○	○	Numbness in feet or legs	○	○	Herniated/Bulging Discs
○	○	Asthma	○	○	Painful/Swollen Joints
○	○	Sore heels when walking	○	○	Artifical/Missing limbs
○	○	Cold Hands or feet	○	○	Low Back Pain
○	○	Anxiety	○	○	Fainting Spells
○	○	Swollen ankles	○	○	High or Low Blood Pressure (circle)
○	○	Depression	○	○	Seizures
○	○	Sinus Conditions	○	○	Cancer *Type:* _____ *PastTreatment:* _____ *CurrentTreatment:* _____
○	○	Frequent Colds			
○	○	Trouble falling asleep			
○	○	Trouble staying asleep			
○	○	Hemorrhoids			

Known Biological Family Medical History

Start two generations back and include siblings.

	Relation to you	Still Living?	Cause of Death	Age	Major Health Issues
1					
2					
3					
4					
5					
6					
7					

Food Diary

Please log your food intake for three days prior to you appointment.

DAY ONE

Breakfast:

Lunch:

Dinner

Snacks:

Beverages:

DAY TWO

Breakfast:

Lunch:

Dinner

Snacks:

Beverages:

DAY THREE

Breakfast:

Lunch:

Dinner

Snacks:

Beverages:

Digestive Health

What dietary restrictions do you have? _____

Water Intake (glasses per day): _____ Caffeine (type/amount): _____

Are you subject to binge eating? _____ What foods? _____

Do you experience burps, bloating, or gas after eating? (circle) _____ What foods trigger this? _____

Do you use Tobacco? ___ How much / How often? _____

Alcohol? ___ How much / How often? _____

Marijuana? ____ How much / How often? _____ Other: _____

Have you been treated for substance use? _____

How often are your bowel movements? _____

Do your stools: Sink ____ Float ____ Constipation? _____ Diarrhea? _____

Blood in stool ? ____ Mucus in stool? ____ Pain when stooling? ____ Other _____

Emotional & Spiritual Health

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 or have a spiritual practice? _____

If so, what do you pray to? _____

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 ____ Other (describe briefly) _____

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? _____

Reproductive Health

Please fill out all that applies to you.

Are you trying to conceive? _____ Are you possibly pregnant? _____

Are you being treated for difficulty becoming pregnant? _____

Describe treatment(s) to date (IUI, IVF, etc) : _____

Method of Contraception (circle) : Pills Patch Injection Diaphragm Condoms

IUD Abstinence Pulling out Fertility Awareness (Charting)

Other: _____ Length of time using method: _____

Last Pap smear: _____ Results: _____

Menstruation

Age of first period: _____ What was this like for you? _____

Last start date of period: _____ Length of monthly cycle : _____

	Past	Present		Past	Present
Painful Periods	○	○	Uterine or Cervical Polyps	○	○
Irregular cycles: *Early ___ Late ___*	○	○	Fibroids *Location (if known): _____*	○	○
Heavy Pelvis before Menses	○	○	Uterine Infection(s)	○	○
Dark Thick Blood (circle): *Beginning End Both*	○	○	Missed periods *How long? _____*	○	○
Excessive Bleeding *Pads/Hour: _____*	○	○	Cysts *Location (if known): _____*	○	○
Headache or Migraine w/ menses	○	○	Bladder Infection(s)	○	○
Dizziness	○	○	Vaginal/Genital Infection(s)	○	○
Bloating	○	○	Urinary Incontinence	○	○
Water Retention	○	○	Painful Intercourse	○	○
Painful Ovulation	○	○	Vaginal/Genital Dryness	○	○
No Ovulation	○	○	Sexually Transmitted Disease *Type: _____*	○	○
Endometriosis *Location (if known) : _____*	○	○			

Pregnancy History

Current Pregnancy: Due Date: _____ Doctor/Midwife: _____

Home/Hospital/Birthing Center: _____

Total number of pregnancies: ____ Number of births: ____ Dates: _____

Briefly describe your experience with:

Pregnancy: _____

Labor: _____

Birthing: _____

Postpartum: _____

Complications: ____ Miscarriages: ____ Terminations: ____ Premature births: _____

Spotting during pregnancy: ____ Weak newborn at birth: ____ Incompetent cervix : _____

Maternal Family History of (please circle):

Cancer (type): _____ Hysterectomy Other: _____

Medications you may have been exposed to in utero (if any): _____

Did you have any trauma at birth? (if known) : _____

Menopause

Do you experience any of the below?

Hot flashes	○	Dry Vagina/Genitals	○
Insomnia	○	Depression	○
Fatigue	○	Anxiety	○
Memory Loss	○	Irritability	○
Mood Swings	○	Spotting	○
Vaginal/Genital Discharge	○	Flooding *Pads/Hr:* _____	○

Age symptoms began: ____ Are they getting worse? ____ Better ____ Same _____

Are you on or have you ever been on hormone replacement therapy? _____ How long?_____

Name and dose: _____

Reason for stopping: _____

Age of biological mother at menopause: _____ Concerns/Experience: _____

Sexual wellbeing - please fill out to your comfort level

Rate your interest in Sex: Insatiable _____ High ___ Moderate ___ Low _____ None _____

Do you have or did you ever have difficulty experiencing orgasms? _____

Do you have a history of: Rape ____ Trauma ____ Incest ____

If so, when? _____ Did you undergo counseling for this? _____

Did you find counseling helpful? _____

Pelvic and Genital Issues and Pain

Pain or Discomfort in (circle) :

Penis Testicles Perineum Rectum Urinary Tract Labia Vagina Clitoris

Pain or Discomfort in groin or inner thighs (circle) : Left Right Both

Frequent infection in: UTIs ____ Bladder _____ Kidney _____ When? _____

Difficulty with arousal or erection (circle) :

Obtaining Maintaining Painful Painful ejaculation

Urinary Difficulty (circle) : Difficult starting Weak flow Interupted flow Painful Urination

Urinary Retention Bedwetting Nocturnal Urination (Times per night?): _____

Do you have any sexually transmitted disease(s)? _____

Do you experience pelvic pressure? _____ Pain in lower back, esp after intercourse? _____

Family History of Prostate Disease: Yes ___ No___ Type: _____ Relationship to you: _____

Results of PSA (Prostate Specific Antigen) Test if known: _____ Date : _____

Results of Sperm Analysis : Count : ____ Motility : ____ Morphology : ____ Date done: _____

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

_____

_____

Business Policy

Please read and sign below.

Mission:
Our mission is to serve those who seek our guidance with compassion and dedication to the health of our planet. We utilize traditional healing techniques and contemporary medical knowledge in order to help our clientele navigate their health.

Please familiarize yourself with my business policies so that we may provide you with the best experience possible.

Cancellations:
Wildflowers Wellness has a 48 hr cancellation policy. Non-emergency cancellations will be charged the full amount for the appointment. If you have a contagious disease, please notify the office before the appointment and we will determine the best plan of action.

Late arrivals:
Late arrivals are charged the full amount for the appointment.

Billing:
Payment is due at time of service. An initial visit is typically 2 hours long and costs $240. Follow up visits are 1.5 hours long and cost $180. When subsequent sessions are longer or shorter, the hourly rate is $120 per hour, billed in 15 minute increments.

Please initial to agree to the following:
____ I understand that I am not to do the uterine portion of the self-care massage if I have an IUD, may be pregnant, or during my period.
_____ I agree that the self-care massage is for my self-care only, not to be performed on others.

Breast massage will not be performed without prior written consent.
_____ Initial if you give consent to breast massage.

I understand that nutritional and herbal supplements provided by Wildflowers Wellness are to be used under Wildflowers practitioner care, and are refillable through the Wildflowers Wellness office only.

Print Name _____ Email _____
Signature _____ Date _____