Massage Therapy Agreement and Release of Liability

Name: ____________________________________ Address: ____

Cell Phone: ____________________________ City:____

Email: ____State: ___________Zip_______________

Birthday for discount: _______________________

Welcome to A Touch Above Women's Holistic Wellness. We're delighted you have chosen our massage therapy & holistic services. No female genitalia and women's breast will NOT be exposed at any time. Draping will be used during the session. If during the session you feel uncomfortable, then ask your therapist to end the session. **Due to table weight restrictions & liability, we are unable to see any clients who weigh over 275 pounds.**

It is your responsibility to inform the therapist of any pre-existing conditions, limitations or specific sensitivities and to inform your therapist if you feel any discomfort during the session. If you do feel discomfort, please ask your therapist to adjust the level of pressure. You understand and voluntarily accept any risk of which you have been advised associated with your massage, or from any use of this facility, and hereby release A Touch Above (including its employees, practitioners, agents, and insurers) from all liability for any injury, including, without limitation, personal, bodily or mental injury, economic loss or any damage to you resulting there from. You release all liability if you are over 275 pounds and the table breaks. You further hereby release all of the foregoing personnel and entities from all liabilities arising from any such injury or damage resulting from your failure to disclose any pre-existing condition, limitation, or specific sensitivities, or your failure to inform your therapist of any discomfort during the session. Your therapist may determine that it is unsafe for you to proceed with or continue a therapeutic session due to health-related concerns. In this event you may be required to provide A Touch Above with a physician's medical release prior to continuing treatment.

The undersigned acknowledges that she had read this agreement.

Signature: ____ Date: ______________

The Arvigo Techniques of Maya Abdominal Therapy™
Confidential Intake Form

Date of Initial Visit____________________

Name:____

Address____

State___________________________Zip_________ Home Phone____

Work Phone_____________________Cell________________________email________________________________

Date of Birth_____________________ Age__________Occupation____

Marital/Relationship status______________________Referred by____

Client Confidentiality and Release Form

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 his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations (unless specified under his/her professional scope of practice). 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 therapist/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 best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

I, (name)____

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

Client Signature: ____ Date: __________________________

Practitioner signature____Date:________________________

Client Initials: ______________Case Study #___________________Age_________Male_______Female________
Date of Visit:______________________Practitioner 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:

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?

Female Reproductive Health History

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

Fertility Awareness Other:______________Length of time using method________Last Pap smear____Results _____

Are now or in the past experiencing Fertility Challenges? Yes___No___Describe your treatment :_________________

(IUI, IVF,etc)____

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? Yes_____No_______ Are you Pregnant? Yes____No____Unsure____

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?			

Rate your interest in Sex: High_________Moderate__________Low______________None___________________

Do you have or ever had difficulty experiencing orgasms____

Have you experienced trauma? Yes___No____Describe____

Did you undergo counseling for this____

What was this like for you____

Pregnancy History Pregnancy History

Number of Pregnancies:_____Dates________Miscarriage(s)_______Dates_______Termination(s)______Dates:__________

Number of Births:_________ Dates:____

Complications for any of the above, describe:____

Premature Births?______ Spotting During Pregnancy? _____Weak Newborns? ______Incompetent Cervix? _______

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) ____

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: