



massage • acupuncture • herbs • nutritional counseling • yoga  
16 East 40<sup>th</sup> Street, 2<sup>nd</sup> Floor  
New York, NY, 10016  
212-685-0985

### CONFIDENTIAL MASSAGE INTAKE FORM

Name: \_\_\_\_\_ Date of Initial Visit \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ email \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
Marital status \_\_\_\_\_ Referred by \_\_\_\_\_  
Have you had massage/bodywork before? \_\_\_\_\_ What type? \_\_\_\_\_

### REASON FOR VISIT

What is your primary concern? \_\_\_\_\_  
What are other areas of concern? \_\_\_\_\_  
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 \_\_\_\_\_  
Describe your exercise routine (type,  
frequency) \_\_\_\_\_

### FAMILY HISTORY

Alive? Age/Cause of Death Major Health Issues  
Mother: \_\_\_\_\_  
Father: \_\_\_\_\_  
Siblings: \_\_\_\_\_  
Maternal Grandmother \_\_\_\_\_

Maternal Grandfather \_\_\_\_\_

Paternal Grandmother \_\_\_\_\_

Paternal Grandfather \_\_\_\_\_

Family History of Abuse \_\_\_\_\_ circle if applicable : physical emotional sexual spiritual

Family History of Substance Abuse \_\_\_\_\_ Suicide \_\_\_\_\_ Other Trauma \_\_\_\_\_

### DIGESTION & ELIMINATION

Typical

Breakfast: \_\_\_\_\_

Typical

Lunch: \_\_\_\_\_

Typical

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_ Water \_\_\_\_\_

Intake(glasses/day) \_\_\_\_\_ Caffeine \_\_\_\_\_

What is the worse thing on 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? \_\_\_\_\_ Do your stools:

sink \_\_\_\_\_ float \_\_\_\_\_

Constipation? \_\_\_\_\_ Blood in stool ? \_\_\_\_\_ Mucus in stool? \_\_\_\_\_ Pain when stooling? \_\_\_\_\_

Other

concerns \_\_\_\_\_

### 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 or have a spiritual practice \_\_\_\_\_

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 \_\_\_\_\_

What changes would you like to achieve in 6 months \_\_\_\_\_

One Year \_\_\_\_\_

### MEDICAL HISTORY

Are you currently under the care of another health care practioner(s)? \_\_\_\_\_ Reason(s) \_\_\_\_\_

Name(s) of

Practitioner \_\_\_\_\_ Address: \_\_\_\_\_

Phone \_\_\_\_\_ email \_\_\_\_\_

Current

Medications: \_\_\_\_\_

Allergies: specify allergen and

reaction: \_\_\_\_\_

Supplements/Remedies \_\_\_\_\_

Do you use Tobacco? \_\_\_\_\_ Quantity \_\_\_\_\_ /ppd Alcohol? \_\_\_\_\_ Quantitiy \_\_\_\_\_ ounces/ day

Marijuana? \_\_\_\_\_ Quantity \_\_\_\_\_ Other: \_\_\_\_\_ Have you been under treatment for  
substance use? If so, describe: \_\_\_\_\_

Surgical History (year and type) \_\_\_\_\_

Recent Procedures: \_\_\_\_\_

**Hospitalizations**

---

---

---

**Accidents or**

**Traumas** \_\_\_\_\_

**Falls/Injuries to Sacrum/head/tailbone**

**(describe)** \_\_\_\_\_

**Birth Trauma if known**

---

*Circle any of the following you are Currently experiencing*

*Underline and of the following you have experienced in the Past*

Headaches (migraine, tension, cluster)      Ringing in Ears      Pins and needles in arms, legs, hands or feet

Asthma      Cold Hands or Feet      Swollen ankles      Sinus Conditions      Seizures

Loss of Smell or Taste      Skin Disorders: Acne, Fungus, Psoriasis Other: \_\_\_\_\_

Sciatica      Painful Joints      Swollen Joints      Spinal Problems      Anxiety      Fatigue

Trouble Sleeping      Fainting Spells      Loss of Memory      Depression

Muscular Tightness: (location) \_\_\_\_\_

Varicose Veins (location) \_\_\_\_\_

Herniated or Bulging disc: (location) \_\_\_\_\_      High or Low Blood Pressure

Contact lenses      Dentures      Artificial /Missing limbs      Frequent Colds/ Upper Respiratory conditions

**FEMALE ~ REPRODUCTIVE HEALTH HISTORY**

Age of Menarche \_\_\_\_\_ What was this like for you \_\_\_\_\_

---

How many Pregnancie(s) have you had? \_\_\_\_\_ Number of Deliverie(s) \_\_\_\_\_

Dates \_\_\_\_\_

Termination(s) \_\_\_\_\_ When \_\_\_\_\_

Miscarriage(s)? \_\_\_\_\_ When \_\_\_\_\_

Complications \_\_\_\_\_

What was your experience of:

Pregnancy \_\_\_\_\_

Labor \_\_\_\_\_

Delivery \_\_\_\_\_

Post Partum \_\_\_\_\_

Medications your mother took when she was pregnant with you (if any) \_\_\_\_\_

Maternal Family History (Includes, mother, sisters, grandmother, aunts-as known) (please circle)

Infertility                  Fibroids                  Endometriosis                  Cancer(type) \_\_\_\_\_

Menstrual Problems                  Menopause                  PMS

Your History

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

Other: \_\_\_\_\_

Length of time on synthetic contraception (Pill, Patch or

Injection): \_\_\_\_\_

Last Pap smear \_\_\_\_\_ Results ( if known) \_\_\_\_\_

Date of Last Menstrual period \_\_\_\_\_ Length of Menses \_\_\_\_\_

Episodes of Amenorrhea \_\_\_\_\_ When \_\_\_\_\_ For how long \_\_\_\_\_

Please circle as appropriate:

Painful periods                  Irregular (late or early)                  Dark Thick Blood at Beginning or End of Cycle

Dizziness with period                  Headache or Migraine with period                  Excessive Bleeding (> one pad/hour)

PMS/Depression with or before period                  Failure to Ovulate                  Painful Ovulation

Bloating/water retention with period                  Heaviness or pressure in lower pelvis with period

Other Symptoms (Circle and Describe as indicated)

Varicose veins of leg                  Tired weak legs

Numb legs and feet when standing still                  Sore heels when walking

Low back ache                  Painful intercourse                  Constipation                  Endometriosis

Endometritis                  Uterine Polyps                  Fibroids (Size and Location if known) \_\_\_\_\_

**Uterine infections**      **Frequent urination**      **Bladder infections**      **Vaginal discharge (describe)**  
**Vaginitis**      **Vaginal Yeast infections**      **Chronic miscarriages**      **Premature deliveries**  
**Weak newborn infants**      **Difficult pregnancy**      **Incompetent cervix**      **Spotting with pregnancy**  
**Pelvic Inflammation**      **Sexually Transmitted Disease (date and type)** \_\_\_\_\_  
**Dry vagina (without menopause)**      **Difficult menopause**  
**Cancer(cervix, bladder, uterus, ovarian, bladder, bowel)**      **Cysts (ovarian or breast)**

**Are you under the treatment for Infertility** \_\_\_\_\_ **Describe current treatment to date**  
**(IUI,IVF,etc):** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Gynecological**

**Practioner:** \_\_\_\_\_ **Address** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Rate your interest in Sex:**

**High** \_\_\_\_\_ **Moderate** \_\_\_\_\_ **Low** \_\_\_\_\_ **None** \_\_\_\_\_

**Do you have or ever had difficulty experiencing**

**orgasms** \_\_\_\_\_

**Have you experienced a history of rape** \_\_\_\_\_ **trauma** \_\_\_\_\_ **incest** \_\_\_\_\_ **If so,-when** \_\_\_\_\_

**Did you undergo counseling for**

**this** \_\_\_\_\_

**Was counseling helpful?**

\_\_\_\_\_

**MENOPAUSE (Circle the symptoms that apply to you)**

**Hot flashes Insomnia Fatigue Memory Loss**

**Mood swings Irritability Vaginal discharge (describe):**

**Dry Vagina Fatigue Depression Spotting (menses)**

**Flooding Clotting Irregular menses Increased/Decreased Libido**

**Other symptoms not listed above** \_\_\_\_\_

---

---

**When did these symptoms**

**begin:** \_\_\_\_\_

**Are they getting worse** \_\_\_\_\_ **better** \_\_\_\_\_ **same** \_\_\_\_\_

**Last Menstrual period** \_\_\_\_\_

**Are you on/ or ever been on hormone replacement therapy?** \_\_\_\_\_ **if so, how long** \_\_\_\_\_

**Name and dose** \_\_\_\_\_

**Reason for stopping** \_\_\_\_\_

**Other medications/herbal remedies** \_\_\_\_\_

**Age of Mother at**

**menopause:** \_\_\_\_\_ **Concerns/Experience** \_\_\_\_\_

**Additional Comments:**

**Please read and sign**

**I understand that payment is due at the time of treatment unless arrangements have been made other wise.**

**I agree to give at least 24hourse notice of cancellation of appointment. Cases of extreme emergency are considered exceptions to this cancellation policy.**

**I understand the treatment here is not a replacement for medical care.**

**I understand that Karen Kelly does not diagnose medical illness, disease or any other physical or mental conditions (unless specified under her professional scope of practice)**

**As such, Ms. Kelly does not prescribe medical treatment of pharmaceuticals, nor does she perform any spinal manipulations .**

**I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.**

**I have stated all my known conditions and take it upon myself to keep Ms. Kelly updated on my health.**

**Client**

**signature\_\_\_\_\_Date\_\_\_\_\_**

**Therapist/Practitioner**

**signature:\_\_\_\_\_Date\_\_\_\_\_**

**Client Confidentiality Release Form**

I, (name) \_\_\_\_\_ address \_\_\_\_\_

Phone \_\_\_\_\_ email \_\_\_\_\_

give my permission, for my therapist, Karen Kelly to take notes about me, including health history/ medical and /or personal information I choose to disclose to him/her.

I understand that this information may be used for the purpose of practitioner certification and will be shared with the Arvigo Institute, LLC .

I also understand that this information will anonymously be used for the Arvigo Institute, LLC . for statistical purposes, and that my practitioner may use this information to provide me with a summary for my own personal use.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_