The Arvigo Techiques of Maya Abdominal Therapy

Erika Lutwin, BS, LMT

MAYA Abdominal Client Intake Form

Name _____ Age _____ Date of first visit _____

Primary reason for visit _____

When did you 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

Name(s) of Practitioner _____ Address _____

Phone _____ Email _____

Current Medications and/or Supplements/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:

4317 E. Genesee St., Suite 201 DeWitt, NY 13214 / 315.317.0588

Digestion and Elimination

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? _____

How often are your bowel movements? _____ Do your stools: sink _____ float _____

Constipation? _____ Blood in stool? _____ Mucus in stool? _____ Pain when stooling? _____

Emotional and 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 to or have a spiritual practice _____

On a scale of 1-10 (1being the lesser, 10 the greater) Please rate yourself:

Faith _____ Hope _____ Chairity _____ 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:

Describe your exercise routine (type, frequency) _____

What changes would you like to achieve in 6 months _____

One year _____

Female Reproductive Health History

When did you begin your menses _____ What was this like for you _____

How many Pregnancy(s) have you had? _____ Number of Births) _____ Dates _____

Termination(s) _____ When _____

Miscarriage(s) _____ When _____

Complications _____

What was your experience of:

Pregnancy _____

Labor _____

Birthing _____

Post Partum _____

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

Birth Trauma (if known) _____

Method of Contraception: ☐ pills ☐ patch ☐ diaphram ☐ injection ☐ condoms ☐ IUD ☐ abstinence ☐ rhythm method

Fertility Awareness Other: _____ Length of time using method _____

Last Pap smear _____ Results (if known) _____

Date of Last Menstrual period _____ Length of Menses _____ Are you Pregnant/Trying to Conceive _____

Episodes of Amenorrhea _____ When _____ For how long _____

Are you under the treatment for Infertility _____ Describe current treatment to date _____

IUI, IVF, etc _____

Gynecological Provider _____ Phone _____

Provider's address _____

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 _____

What was this like for you:

Please check as appropriate:

- ☐ Painful periods
- ☐ Dark, thick blood at beginning of cycle
- ☐ Headache or migraine with period
- ☐ Bloating/Water retention with period
- ☐ PMS/Depression with or before period
- ☐ Failure to ovulate
- ☐ Varicose veins
- ☐ Numb legs and feet when standing
- ☐ Low back ache
- ☐ Constipation
- ☐ Endometritis/Uterine infections
- ☐ Fibroids
- ☐ Bladder infections/incontinence
- ☐ Weak newborn infants
- ☐ Incompetent cervix
- ☐ Pelvic inflammation
- ☐ Dry vagina
- ☐ Cancer, especially of reproductive area
- ☐ Irregular cycles (early or late)
- ☐ Dark thick blood at the end of cycle
- ☐ Dizziness with period
- ☐ Heaviness in pelvis with period
- ☐ Excessive bleeding (> one pad/hour)
- ☐ Painful ovulation
- ☐ Tired weak legs
- ☐ Sore heels when walking
- ☐ Painful intercourse
- ☐ Endometriosis
- ☐ Uterine Polyps
- ☐ Vaginal discharge/vaginitis
- ☐ Chronic miscarriage
- ☐ Premature deliveries
- ☐ Spotting with pregnancy
- ☐ Sexually transmitted disease
- ☐ Difficult menopause
- ☐ Cysts, especially breast/ovarian
- ☐ Other _____

Maternal Family History of (please check) ☐ Infertility ☐ Fibroids ☐ Endometriosis ☐ PMS ☐ Menopause

Cancer (type) _____ Menstrual Problems _____

Other _____

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

☐ Increase libido ☐ Decrease libido ☐ Disturbed sleep pattern

Additional comments:

Male Reproductive Health History

Please check the symptoms below that apply:

	Past	Present
Painful urination	☐	☐
Urinary Incontinence or dribbling	☐	☐
Weak or interrupted urine flow	☐	☐
Pain or burning with urination	☐	☐
Nocturnal urination How many times?	☐	☐
Pain in lower back, esp after intercourse	☐	☐
Pain or discomfort in: Penis Testicles Rectum	☐ ☐ ☐	☐ ☐ ☐
Frequent bladder or kidney infections When?	☐	☐

	Past	Present
Urinary retention	☐	☐
Difficult starting or holding urine stream	☐	☐
Blood or puss in urine	☐	☐
Pelvic pressure	☐	☐
Insatiable sex drive	☐	☐
Pain or discomfort between scrotum and testicles	☐	☐
Pain or discomfort in inner thighs: Left Right Both	☐ ☐ ☐	☐ ☐ ☐
Erection: Difficulty in obtaining Maintaining Painful ejaculation	☐ ☐ ☐	☐ ☐ ☐

Additional comments:

I understand that I should see a doctor or other appropriate health providers for diagnosis and treatment of any suspected medical problem. It may be beneficial for my massage practitioner to speak to my doctor about my medical condition to determine how massage may help the healing process, and to avoid worsening the condition. I will be asked permission to contact my doctor, if the massage practitioner thinks that it might be useful. I also understand that it is my responsibility to keep my massage practitioner informed of any changes in my health, and any medications that I may begin to take in the future.

Signature _____ Date _____

Please complete and print out form and bring to next appointment.