AWARENESS IS HEALING® Intake Form

Thank you for taking the time to fill out this questionnaire. It is somewhat lengthy but important to our overall treatment success.
This information will be held in the strictest confidence.

PERSONAL INFORMATION

First Name: _____Last Name: _____ Preferred Name: _____

Sex: Male, Female, or X:_____Preferred Pronouns: _____Gender: _____Date of Birth_____/_____/_____

Address _____

City_____State_____Zip_____

Phone Number: _____ E-mail _____

Occupation_____ Employer_____

Marital Status _____ If not married do you have a significant other _____

Do you have children _____ ages? _____

Emergency Contact_____ Relation_____Phone Number:_____

***How did you hear about Our Services*?** _____

BACKGROUND INFORMATION

Have you had massage or bodywork before? (If so, where, when, what type, frequency) _____

_____

Do you exercise regular, participate in sports or yoga? (If so, what type and frequency) _____

_____

Do you stretch? (If so, number of times per week) _____

SPECIFIC COMPLAINT

What are your major areas of pain or concern? _____

_____

When did you first notice it? _____ What brought it on?_____

What activities aggravate it? _____

At or around the time of the onset were there other emotional stresses occurring? _____

Is this condition getting worse? _____ Does it interfere with work?_____sleep_____recreation_____

What have you done to get relief? _____

Have you sought a diagnosis? _____ By whom?_____Diagnosis_____

Other areas of pain or concern_____

_____

STRESS LEVEL

What is your current stress level? (low) 1 2 3 4 5 (high) Is the stress positive, negative or both?_____

How many hours of sleep do you get in an average night? _____

Do you usually wake feeling rested? _____ Tired? _____ Other? _____

Anxiousness: Often Sometimes Seldom

Explain _____

Depression: Often Sometimes Seldom

Explain_____

Apathetic: Often Sometimes Seldom

Explain _____

DIGESTION & DIET

Typical Breakfast_____

Typical Lunch_____

Typical Dinner_____

Snacks_____

How many times a week do you dine out? _____How many glasses of water per day? _____

Do you prefer Ice Cold Drinks or Hot Drinks? _____How is your appetite? _____

Do you crave certain foods? (what, when, do you actually go get it?) _____

How do you feel about your diet?_____

What would you say is the worst thing about your diet?_____

How is your digestion? (Bloating? Sour burps? Heartburn? Gas? Etc.) _____

Are you on a restricted diet? (type of foods, frequency of eating)?_____

Do you have any food allergies or intolerances?_____

Do you have a history of eating disorders?_____Explain_____

Bowel movements (circle what applies): Daily Regular schedule Irregular schedule

Constipation (frequency _____) Hard Stools Soft Stools

Urination (circle what applies): Normal Scanty Frequent Burning Strong Odor Dark Color

Any history of bladder or kidney infections? (If so please list age also)_____

FAMILY HISTORY

	Sex	Still Living?	Age	Cause of Death	Major Ailments
Biological Grandparent 1	M F X				
Biological Grandparent 1	M F X				
Biological Grandparent 2	M F X				
Biological Grandparent2	M F X				
Parent 1	M F X				
Parent 2	M F X				
Siblings, How Many___	M F X				
	M F X				

(Siblings, How Many___	Sex	Still Living?	Age	Cause of Death	Major Ailments
	M F X				
	M F X				
	M F X				

Is there a history of abuse in your family?_____(circle what applies) emotional physical sexual spiritual drug alcohol (explain)

_____

Is there a history of suicide in your family?_____

EMOTIONAL & SPIRITUAL

Are you romantically involved? _____How is your relationship? (Is it satisfying?) _____

Were there any emotional traumas in your early or present life? (rape, great loss, suicide, death, change of life style, etc.)_____

_____

If possible, please explain any negative emotion you may experience_____

_____

When do you feel this emotion? Where are you when you feel this?_____

What is your opinion of yourself?_____

Have you ever been to counseling? (If so, what was the outcome?)_____

Do you put time or energy into a relationship with a higher power? _____

Do you meditate? (If so, how often?) _____

Is there an unrealized longing in your life? (If so, what is it and what would fulfill it)_____

Are you involved in activities outside of work? (Social, recreational, sports, etc./frequency) _____

Hobbies or interests? _____

BIRTH & EARLY CHILDHOOD

If known, what medications did your mother take when she was pregnant with you_____

Circle the type of birth you had: Normal Difficult Trauma at Birth Unknown

Additional Notes:_____

_____

_____

_____

_____

Explain your early relationship with each of your parents

Explain your present relationship with each of your parents

Explain any notable or adverse relationships with your siblings.

MEDICAL HISTORY

Are you currently under the care of a doctor, chiropractor, or other health care practitioner? (include their names & locations)_____

_____

If so, for what conditions and when did you last see them?_____

Have you ever had physical therapy or pelvic floor therapy for a specific condition? Dates of treatment? For and what condition? What was the outcome?_____

_____

List any medications, herbal remedies, supplements, over-the-counter medications that you are taking (including frequency)_____

_____

Do you have any allergies in general or to specific medications? (If so, please explain)_____

_____

Any Broken bones? (include year)_____

Any Surgeries? (include year)_____

_____

Any other trauma or hospitalizations? (include year)_____

Any medications you took as a child? (Include year and duration) _____

Childhood accidents or physical traumas? _____

Have you ever hit or fallen on your tailbone? _____

Are you currently under care for any mental health conditions or are you seeking treatment? If so, please explain. Please list your provider's name.

_____

Have you ever been diagnosed with a mental health condition that you are not seeking treatment for? If so what diagnosis?

_____

_____

Circle any of the following you are CURRENTLY experiencing and Underline any you have had as a PAST problem:

Headaches	Ringing in Ears	Pins & Needles in arms/hands	Pins & Needles in Legs
Shooting pain in head	Asthma	Cold Hands	Cold Feet
Sinus Trouble	Epilepsy or other seizures	Heart Pain	Swollen Ankles
Loss of Smell	Muscle Spasm in Neck	Blood Clots, Phlebitis	Pain in legs and feet
Loss of Taste	Tingling in Neck	Skin disorders, acne, fungus, rash	Sciatica
Tightness in throat	Tightness in shoulders	Painful Joints	Numb hands/feet
Face Flushed	Painful Menstruation/Cramps	Swollen Joints	Constipation
Loss of Memory	ARFID	Pins & Needles in Back	Allergies
Fatigue	Sensitivity to oils and lotions	Herniated or Bulging Disk	High or Low Blood Pressure
Depression	Lung or Breathing Problems	Pinched neck in back	Spinal Problems
Head feels too heavy	Pregnancy	Arthritis, Osteoporosis, Brittle Bones	Diabetes
Varicose Veins/Circulatory Problems	Fainting Spells	Hepatitis	Emotional Problems
Frequent Flu or Cold	Anorexia/Bulimia	Cancer	Bad Breath
Heart Problems	Kidney Problems	Swollen Prostate	HIV
Pelvic Floor Pain	SIBO		

FEMALE REPRODUCTIVE HEALTH

Circle any of the following situations that women on your mother's side of the family have:

Infertility	Menstrual Problems	Childbirth
Difficult menopause	Cancer	Heart Trouble

Do you experience heaviness in the lower pelvis as menses begins? _____

How many days does your period last? _____ Date of your last period _____

Do you experience no periods at all? (If no periods, please explain)_____

Circle any of the following situations that describe your menstrual patterns:

Painful Periods	Late, early, or irregular	Dizziness with period
Dark, thick blood at onset of menstruation	Excessive bleeding (more than one pad/hour)	Failure to ovulate regularly
Headache or migraine with period	Blood clots during menstruation	Painful Ovulation
PMS/Depression with or before period	Bloating or Water Retention with period	

Circle any of the following signs or symptoms that apply:

Varicose Veins of the legs	Numb legs & feet, especially when standing still	Tired Weak Legs
Sore heels when walking	Low back ache	Painful Intercourse
Constipation	Endometriosis	Endometritis
Uterine Polyps	Uterine Fibroids	Uterine Infections
Frequent Urination Bladder Infections	Vaginal Discharge (what color)	Vaginal yeast conditions/vaginitis
Chronic Miscarriages	Premature Deliveries	Weak Newborn Infant
False Pregnancies	Pelvic Inflammation	Sexually Transmitted Disease
Ovarian or Breast Cysts	Difficult Pregnancy, Incompetent Uterus, Spotting	Difficult Menopause
Cancer of the cervix, uterus, bladder, or lower bowel		Dry vagina with or without menopause

List any other signs or symptoms not included on the list: _____

_____

Do you remember if you had any serious falls or accidents? (Explain and list age) _____

Are you now or have you ever taken birth control pills? (If so, when and for how long) _____

Are you now currently using an IUD as birth control, or do you plan to? _____

Do you have or have you ever had fertility problems? _____

Are you currently pregnant? _____If Yes: how many weeks? _____

How many pregnancies have ever had? _____ Number of deliveries: _____

Have you presently or recently been under a doctor's care for gynecological problems? _____

Rate your interest in sex: High Moderate Low None

Do you have difficulty achieving orgasms? (If so, explain)_____

Were you ever raped? (If so, at what age did this occur)_____

Are you a survivor of incest? (If so, at what age)_____

If you did experience rape or incest, did you receive counseling for this? (If so, what was the counseling like for you? Did it help?)

_____

_____

Have you experienced a period every two weeks within the past few years? _____

If Menopause applies, please circle applicable symptoms or situations and list approximate age when they began:

Hot Flashes	Memory Loss	Insomnia
Mood Swings	Vaginal Discharge (color)_____	Fatigue
Depression	Estrogen Replacement Therapy (for how long) _____	

List any herbal remedies, vitamins, supplements, fertility drugs, or natural products you are presently taking

_____

MALE REPRODUCTIVE HEALTH

Circle any of the following signs or symptoms that apply:

Painful Urination	Bladder Kidney Infections	Difficulty obtaining an erection	Painful or no Ejaculation
Frequent Urination	Nocturnal Urination	Difficulty maintaining an erection	Swollen prostate/prostatitis
Low Sperm Count		Low Sperm Motility	Sexually Transmitted Disease
Irregular Sperm Morphology		Pelvic Pain	

When did you first notice these symptoms? _____ Are they getting better or worse, describe_____

_____

Current medications, supplements or treatments_____

_____

Family history of prostate disease_____Type_____

Relationship_____

Do you have or have you ever had fertility problems? _____

Have you presently or recently been under a doctor's care for gynecological problems? _____

Rate your interest in sex: High Moderate Low None

Do you have difficulty achieving orgasms? (If so, explain) _____

Were you ever raped? (If so, at what age did this occur) _____

Are you a survivor of incest? (If so, at what age) _____

If you did experience rape or incest, did you receive counseling for this? (If so, what was the counseling like for you? Did it help?)

_____

_____

AWARENESS IS HEALING® METHOD

AIH - Awareness is Healing® Method – Is a modality based in the Traditional Maya Medicine belief that trauma, repeated stress, and unresolved emotions cause an undue increasing pressure within the body - resulting in many chronic physical health conditions such as digestive disorders, reproductive issues, pelvic pain, anxiety and more. Because the abdomen is where all vital organs are located including the respiratory and pelvic diaphragms; one of the main components of the Awareness is Healing Method utilizes *Maya Abdominal Massage** to facilitate simultaneous awareness of physical and emotional restrictions, this allows the nervous system to ***release, reset*** and ***restore*** - thus providing lasting and empowering solutions to chronic, acute and everyday health conditions.

Maya Abdominal Massage - is a Traditional Maya Medicine technique that works deeply into abdominal fascia -- releasing physical and emotional congestion, thus improving whole body circulation, enhancing organ function, stabilizing the nervous system, and optimizing overall health and well-being. It combines up to date knowledge of anatomy and physiology to address current medical conditions and provide a wholistic and intuitive approach for the select needs of each individual.

PATIENT/CLIENT MUST READ AND SIGN PRIOR TO INITIAL TREATMENT.

I have completed this information form to the best of my knowledge. I understand that massage/bodywork services are designed to be a health aid and are in no way to take the place of a doctor's care when indicated. I understand that massage therapists/bodyworkers are not qualified to perform spinal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the session(s) will be construed as such.

The therapist or client reserves the right to end the session at any time if massage/bodywork is contraindicated. Information I receive during any session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

I understand that all emotional triggers cannot be fully predicted when there have been years of armoring. I also understand that if at any point during the session I am triggered or uncomfortable with anything at all, I agree to voice it to the practitioner so that they can stop all together and /or provide modification with agreed verbal consent before proceeding.

Signature_____Date_____

Name of Parent or Guardian if minor under 18 (Name & Relation) _____

Guardian Signature_____Date_____

***If you are **pregnant or within 5 years of postpartum** you need to complete the two additional intake forms that can be found clicking on the links below: www.centeredspirit.com/forms.