rebirth holistic women's wellness

3150 California Street, Suite 4
San Francisco, CA 94115

CONFIDENTIAL INTAKE FORM

Date of Initial Visit_____ Referred by _____

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell_____ Email_____

Date of Birth_____ Age_____

Occupation_____ Marital/Relationship status_____

Client Confidentiality Release Form

- I understand that payment is due at the time of treatment unless arrangements have been made otherwise. Payment may be made by cash, check or credit card. Unfortunately Amex and HSA cards are not accepted.
- I understand that there is a **24 hour cancellation policy** and payment in full is due for a missed appointment. Cases of emergency are considered exceptions to this policy.
- I understand that treatment with Rebirth Midwifery is not a replacement for medical care.
- I understand that the treatment with Rebirth Midwifery is not a substitute for 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 Abigail Reagan LM updated on my health.
- The Health Insurance Portability and Accountability (HIPAA), which protects an individual's identifiable health information, requires you to give release to your health care providers to takes notes about your medical, personal and health history. I give my permission for my therapist Abigail Reagan LM to take notes about me, including health history/medical and/or personal information I choose to disclose to her.

Client signature:_____Date_____

Therapist signature:_____Date_____

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

Signature: _____ Date: _____

Revised on 10/19/12

Client Name_____**Age**_____**Date of Visit**_____

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?** _____

Secondary reasons for visit _____

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**_____

Would you like me to consult with any of your other health care providers about your case? _____

Current Medications _____

_____

Vitamins/Supplements/Herbal Remedies_____

_____

Allergies (specify allergen and reaction) _____

Surgical History (year and type) and/or Recent Procedures_____

_____

Hospitalizations _____

Major Illnesses _____

Accidents or Traumas_____

Falls/Injuries to Sacrum/head/coccyx (describe)_____

Other:

Please review and check the following:

Headaches Type:	Past	Present	Pins and needles in arms, legs, Hands or feet	Past	Present
Asthma			Spinal problems		
Cold hands/feet			Anxiety		
Swollen ankles			Depression		
Sinus conditions Frequent colds			Sleep disturbance		
Seizures			Fainting spells		
Loss of smell or taste			Loss of memory		
Skin Disorders Type:			Varicose veins/ Hemorrhoids Location:		
Sciatica			Muscular tension Location:		
Painful/swollen Joints			Herniated/bulging discs		
High or low blood Pressure			Contact lenses		
Dentures/partials			Artificial/Missing limbs		

Other (not mentioned above) _____

Do you use Tobacco?_____ Quantity_____/day Alcohol?_____ Quantity _____ / day

Marijuana?_____ Other:_____ Have you been under treatment for substance use?_____

FAMILY HISTORY

	Still Living?	Cause of Death/Age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother Paternal Grandfather			

DIGESTION AND ELIMINATION

Typical Breakfast_____

Typical Lunch_____

Typical Dinner_____

Snacks_____ **Water Intake (glasses/day)**_____**Caffeine**_____

What is the worst item in your diet?_____ **What foods are your weakness?**_____

Have you ever had anorexia or bulimia?_____

Do you experience bloating/gas/burps after eating?_____ **What foods trigger this?**_____

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

Constipation?_____ **Diarrhea?**_____ **Blood in stool ?**_____ **Mucus in stool?**_____

Pain when stooling?_____

Other concerns_____

Current weight_____ **Height**_____ **Desired weight**_____

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 to 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**_____ **Stress** _____

Other (describe briefly)_____

What are hobbies/ activities that provide you with a sense of pleasure and accomplishment?

_____

Describe your exercise routine (type, frequency)_____

How many hours do you sleep each night? _____**Insomnia?**_____

Changes would you like to achieve in 6 months _____

In One Year_____

FEMALE REPRODUCTIVE HEALTH HISTORY

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

How many Pregnancies have you had? _____

Birth(s)_____ Dates_____

Termination(s) _____ Dates_____

Miscarriage(s) _____ Dates_____

Complications _____

What was your experience of:

Pregnancy_____

Labor_____

Delivery_____

Post Partum_____

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

Birth trauma if known _____

Maternal Family History of (underline) Infertility Fibroids Endometriosis PMS Menopause

Cancer(type)_____Menstrual Problems_____Other_____

Methods of Contraception (underline) pills patch diaphragm depo nuva ring condoms IUD abstinence

rhythm method FAM/Fertility Awareness Method withdrawal

Length of time using each method_____

Last Pap smear_____ Results (if known)_____

Date of Last Menstrual Period_____ Length of Menses_____ Cycle length_____

Episodes of Amenorrhea_____ When?_____ For how long?_____

Are you pregnant/trying to conceive? _____

Are you under treatment for fertility? _____ Describe current treatment to date (meds, IUI, IVF, etc):

_____

_____

Gynecological Provider_____Address_____Phone_____

Rate your interest in sex High_____ Moderate_____ Low_____ None_____ Changes?_____

Do you have or ever had difficulty experiencing orgasms?_____

Have you experienced a history of rape?_____ incest?_____ Trauma?_____ If so, when?_____

Did you undergo counseling for this?_____

What was this like for you?_____

Please check as appropriate:

Painful Periods	**Irregular Cycles (early or late)**
Dark, thick blood at beginning of cycle	**Dark thick blood at the end of cycle**
Headache or Migraine with period	**Dizziness with period**
Bloating/Water Retention with period	**Heaviness in pelvis with period**
PMS/Depression with or before period	**Excessive Bleeding (> one pad/hour)**
Failure to Ovulate	**Painful Ovulation**
Varicose Veins	**Tired weak legs**
Numb legs and feet when standing	**Sore heels when walking**
Low back ache	**Painful intercourse**
Constipation	**Endometriosis**
Endometritis/Uterine Infections	**Uterine Polyps**
Fibroids	**Vaginal Discharge/Vaginitis**
Bladder Infections/Incontinence	**Chronic Miscarriage**
Weak newborn infants	**Premature deliveries**
Incompetent cervix	**Spotting with pregnancy**
Pelvic Inflammation	**Sexually Transmitted disease**
Dry Vagina	**Difficult menopause**
Cancer especially of reproductive organs	**Cysts (especially breast/ovarian)**
Other:	**"Tilted" or retroverted uterus**

PERIMENOPAUSE/MENOPAUSE (check 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**	**Other**		

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_____

Additional Comments: