Maya Abdominal Therapy Initial Intake - *Confidential*

Please complete the following form and return it prior to your appointment.

Name _____ Birthdate _____/_____/_____ Today's Date____/____/_____

Address _____City_____ State _____ Zip _____

Phone (H)_____ (C)_____ E-mail _____@_____

Height_____ Weight_____ Occupation _____

EMERGENCY CONTACT

Name_____ Relationship_____Phone_____

Please list all known allergies (medications, foods, environmental):

What is the primary reason for your visit?_____

Are there any other areas of well-being you are interested in addressing?_____

_____

How would you rate your overall health at this time (Scale of 1-10; 1=poor, 10=excellent) _____

Are you under the care of a physician or other health provider? Yes / No **Date of last visit:**_____

Provider name, phone number, and type of practice (MD, chiropractor, acupuncture, etc):_____

_____

_____

Please list any diagnosed medical problems:_____

_____

Please list any surgeries and/or hospitalizations along with dates:_____

_____

Please list any traumas with date (accidents, broken bones, car accidents, head injuries, etc.**):**_____

_____

What medications are you currently taking, at what dose, and for what reason? Please include prescriptions, over-the-counter drugs, herbs, and vitamin supplements._____

_____

_____

Have you ever experienced an adverse effect to a drug?_____**Herb / supplement?**_____

Please check any of the following conditions or symptoms which apply to you now or in the past:

- ❑ Pregnant, weeks:_____
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Bruise easily
- ❑ Congestive heart failure
- ❑ Heart attack / stroke
- ❑ Other heart problem:_____
- ❑ Pacemaker
- ❑ Blood clotting disorder
- ❑ Varicose veins
- ❑ Broken / dislocated bones
- ❑ Neuropathy / reduced sensation
- ❑ Edema
- ❑ Swollen ankles
- ❑ Muscle strain / sprain, Location: _____
- ❑ Numbness, tingling or paralysis, Location:_____
- ❑ Inflammation, Location:_____ _____
- ❑ Shooting pains, Location:_____
- ❑ Recent fainting or loss of consciousness
- ❑ Sudden changes in sense perceptions, memory, speech
- ❑ Seizures or epilepsy
- ❑ Loss of memory
- ❑ Sensitivity to light
- ❑ Sensitivity to sound / noises
- ❑ Ringing in ears / tinnitus
- ❑ Loss of balance
- ❑ Dizziness
- ❑ Thyroid issue (hypo / hyper)
- ❑ Head feels heavy
- ❑ Asthma
- ❑ Shortness of breath
- ❑ Chronic cough
- ❑ Diabetes, Type:_____
- ❑ Hypo / hyperglycemia
- ❑ Headaches
- ❑ Head injury, concussion, TBI
- ❑ Migraines
- ❑ TMJ disorder and/or grind teeth
- ❑ Splint for bite / TMJ treatment
- ❑ Digestive issues (GERD, too slow or fast, acid reflux, etc)
- ❑ Unusual color of bowel movement (dark / light / blood)
- ❑ Diarrhea
- ❑ Constipation
- ❑ Diverticulitis
- ❑ Unusual abdominal bloating
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Bleeding of any kind (other than regular menses / period)
- ❑ Hands cold
- ❑ Feet feel cold
- ❑ Fever
- ❑ Vomiting
- ❑ Lumps, swellings, sore lymph nodes
- ❑ Unusual or persistent fatigue
- ❑ Night sweats
- ❑ Cancer_____
- ❑ Hernia
- ❑ Hepatitis
- ❑ Autoimmune condition (Lupus, AIDS, Crohn's, Celiac, etc)
- ❑ Ulcers
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Bursitis
- ❑ Arthritis
- ❑ Contact lenses, glasses
- ❑ Blurry vision
- ❑ Anxiety and / or Depression
- ❑ History of abuse (physical, sexual or psychological)
- ❑ Other mental health concern / illness:_____
- ❑ Insomnia
- ❑ Internal pins / wires / artificial joints, Location:_____
- ❑ Chronic pain
- ❑ Low back pain
- ❑ Stiff neck
- ❑ Spinal problem (disc issues, etc)
- ❑ Difficulty raising arm to shoulder height or overhead
- ❑ Sciatica
- ❑ Loss of grip strength
- ❑ Leg or foot cramps
- ❑ Orthotics (custom shoe insoles)
- ❑ Allergies / sensitivities to smells or lotions_____
- ❑ Eczema or Psoriasis
- ❑ Skin infections
- ❑ Athlete's foot, cold sores, or plantar warts

MEN:

- ❑ Erectile dysfunction
- ❑ Benign prostatic hyperplasia
- ❑ Fertility issues / concerns
- ❑ Other:_____

WOMEN:

- ❑ Pregnancies, #_____
- ❑ Miscarriages, #_____
- ❑ Births, #_____
- ❑ Irregular menstrual cycles
- ❑ Painful periods
- ❑ Endometriosis
- ❑ Polycystic ovary syndrome
- ❑ Fibroids
- ❑ PMS
- ❑ Fertility issues / concerns
- ❑ Other:_____

Results of medical test(s), MRI, X-ray, CT scan or lab work completed recently and/or related to chief complaint:

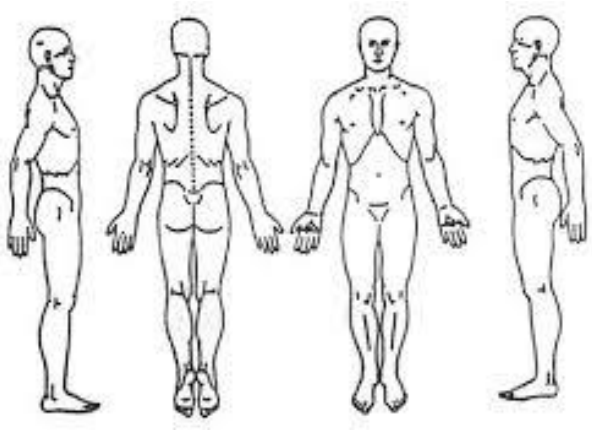
Confidential

Family History

	Living	Age	Deceased	Age at Death	Cause
Father					
Mother					
Siblings, #_____					
Children, #_____					
Spouse / Partner					

Check any conditions which have occurred in blood relatives and their relationship to you:

	CONDITION/ILLNESS	RELATIONSHIP		CONDITION/ILLNESS	RELATIONSHIP
❑	Diabetes	_____	❑	Cancer or tumor	_____
❑	Glaucoma	_____	❑	Tuberculosis	_____
❑	Thyroid problems	_____	❑	Emphysema	_____
❑	High blood pressure	_____	❑	Ulcer	_____
❑	Heart trouble	_____	❑	Arthritis	_____
❑	Stroke	_____	❑	Allergy / Asthma	_____
❑	Kidney / bladder problems	_____	❑	Food intolerance / allergy	_____
❑	Mental illness	_____	❑	Osteoporosis	_____
❑	Addiction / Alcoholism	_____	❑	Autoimmune disorder	_____
❑	Eating disorder	_____	❑	Toxic or chemical exposure	_____
❑	Obesity	_____	❑	Bleeding disorder	_____
❑	Epilepsy	_____	❑	Other:_____	_____



MARK AREAS OF PAIN / DISCOMFORT:

Severity of pain (Scale 0-10, 0=no pain, 10=severe):

At Present _____
At its worst_____
At its best_____

❑Achy ❑Burning ❑Sharp/Stabbing ❑ Dull

Does this interfere with:

❑Work ❑Sleep ❑Exercise ❑Daily activities

Pain / discomfort is better with:

❑Rest ❑Stretching ❑ Exercise ❑ Cold ❑Heat
❑Massage/pressure ❑Other:_____

Pain / discomfort is worse with: ❑Bending ❑ Lifting ❑Sitting ❑Standing ❑Walking ❑Exercise ❑Driving
❑Sneezing ❑Coughing ❑Cold ❑Heat ❑Pressure ❑Other:_____

Please explain any other serious or chronic illnesses, surgeries, or traumatic accidents not already mentioned:

REPRODUCTIVE HEALTH (Women Only)

MENSES

Age at first period (menarche)	
Date of last period	
If you have had a hysterectomy or have already experience menopause, please skip the following section	
Approximate cycle length (how many days from first day of bleeding until next bleeding starts, i.e. 28 days)	
Duration / days of bleeding with each period (please note if some days are just spotting)	
Are your cycles fairly regular (consistent number of days from one cycle to the next)?	
Do you experience cramps? If so, before and/or during the flow?	
How heavy is the flow (how many pads or tampons on heaviest and lightest days)	
Do you experience PMS? If so, what does this look like for you and when does it typically begin?	
Breast tenderness with your period?	
Do you experience any bloating near or during your period?	
Typical color of flow (bright red, dark red, rusty color, purple; please note if it varies during the cycle)	
Do you typically notice any clots? If so, approximately what size are they (pea, cherry, etc) **and what color?**	
Do you notice any changes in your bowel movements around the time of your period (looser, constipation, skinny stools, rabbit pellets, etc)	
Do you use tampons, pad, cup or a combo of these	

Are you currently trying to get pregnant? If so, how long have you been actively trying?

Have you experienced any difficulties or complications with past pregnancies?

Do you typically experience vaginal discharge? ❑Yes ❑ No

If yes, color_____ **Odor**_____

Please note any diagnoses regarding your reproductive health (including diagnostic test results), as well as any other concerns you might have regarding your reproductive health and/or fertility not already answered above:

DIGESTIVE HEALTH

Do you typically notice changes in your bowel movements in response to stress? Medications? Your period? If so, please describe:

Are there any foods or beverages in particular which cause you:

	SYMPTOM	FOOD WHICH CAUSES SYMPTOM
❑	**Bloating**	
❑	**Gas / flatulence**	
❑	**Indigestion**	
❑	**Acid reflux / GERD**	
❑	**Diarrhea and / or loose stools**	
❑	**Constipation**	
❑	**Headaches**	
❑	**Nausea**	
❑	**Foggy headedness**	
❑	**Low energy / fatigue**	
❑	**Canker sores**	
❑	**Other:_____**	

DIET

Typical breakfast	
Typical lunch	
Typical dinner	
Snack foods	
Are there any foods which you avoid?	
Are there any foods or flavors which you crave?	

Please indicate your average intake of the following:

	PER DAY	**PER WEEK**
Tobacco (cigarettes, cigar, pipe, chewing)		
Caffeine (all sources)		
Alcohol		
Sugar		
Soft drinks / soda / pop **Are these diet?_____**		
Recreational drugs_____		
Water	**_____ # 8 oz glasses per day**	

Before today, have you received a professional massage?_____ How often?_____

Have you ever experienced an adverse reaction to or increased discomfort following a massage? If so, please des cribe:

Do you have any of the following today: ❑ Skin rash ❑ Cold/Flu ❑ Fever ❑ Open cuts ❑ Injuries/bruises ❑ Anything contagious ❑ Severe pain ❑ On pain medication

Are you wearing: ❑ Hearing aid ❑ Contact lenses ❑ Hairpiece

How did you hear of my services? ❑Website ❑Referred by_____ ❑Other_____

Please read before signing:

I attest that the above information is complete and correct. I understand massage therapy is provided for stress reduction, relaxation, relief from muscular tension and spasm, and improvement of circulation and energy flow. If I experience pain or discomfort during the session, I will immediately inform you so that the pressure or strokes can be adjusted to my level of comfort. I will not hold you responsible for any pain or discomfort I experience during or after the session. I understand that the services offered today are not a substitute for medical care. I further understand that you are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness. I affirm that I have notified you of all known medical conditions, medications I am taking, and injuries. I agree to inform you of any changes in my health and medical condition. I understand that there shall be no liability on your part should I forget to do so. I understand that massage is entirely therapeutic and non-sexual in nature. I agree to actively participate, as much as possible, in my own healing and health maintenance.
By signing this release, I hereby waive and release Becky Wyland and ESSENTIAL THERAPY, LLC from any and all liability, past, present, and future relating to massage therapy, personal training, wellness counseling, and herbal and nutritional consultations.

Signature_____ Date_____

Pt #_____

Statement of Informed Disclosure

All rules and regulations set forth by the Department of Health are strictly adhered to by this clinic, including proper cleaning and sterilization of equipment and office.

The practice of massage therapy is regulated by the Department of Regulatory Agencies at 1560 Broadway, Suite 1340, Denver, CO 80202 and can be reached at 303-894-7851. Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of the Division of Registrations in the Department of Regulatory Agencies.

Education & Certifications

- Bachelor of Science in Exercise & Sport Science, Colorado State University, Fort Collins, CO
  - Concentration in Wellness Program Mgmt, with emphasis on Cardiopulmonary Rehab
- Certified Clinical Herbalist & Certified Clinical Nutritionist, North American Institute of Medical Herbalism
  - Over 1300 hours of training in herbs, nutrition, and basic medical sciences
- Certified Flower Essence Practitioner, North American Institute of Medical Herbalism
- Certified Massage Therapist, Massage Therapy Institute of Colorado, Denver, CO
  - Over 800 hours of training, including neuromuscular therapy and myofascial release
- Certified Practitioner, Arvigo Techniques of Maya Abdominal Therapy
- Certified Strength & Conditioning Specialist, National Strength & Conditioning Association
- Health & Fitness Instructor, American College of Sports Medicine
- Maya Spiritual Healing, Arvigo Techniques of Maya Abdominal Therapy
- Certified Pilates Instructor, Polestar Pilates
- Acutonics, Level 1 & 2
- Ortho-Bionomy, Spine, Hip, Shoulder, Craniosacral
- Kinesiotaping, Level 1 & 2
- Pediatric Acupuncture, Soma Glick

Fee Schedule

Payment is due at the time of service.

New Patient Evaluation (90 min)	$125*
- Follow-up (90 min)	$125*
- Follow-up (60 min)	$85*
Pediatric (15 years & under)	$50/hr*
Movement Therapy (per 15 min session add-on)	$15*
Kinesiotaping (session add-on)	$10

New Patient Maya Abdominal Therapy (2 hour)	$135*
- Follow-up ATMAT (90 min)	$115*
- Follow-up ATMAT (60 min)	$90*
Initial Herbal Consultation (1 ½ - 2 hours)	$85*
- Herbal Follow-up (30 min)	$35*

*Prices do not include cost of herbs, kinesiotaping, or recommended self-care items (oil, ball, stones, etc)

No-Show / Late Cancellation Policy

We kindly request that you provide at least 24-hours notice should you need to cancel or reschedule an appointment. Failure to do so may result in a Late Cancellation/No Show Fee equivalent to the cost of the scheduled session.

Patient Name_____ Signature_____Date_____

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with massage, exercise instruction, nutritional information and/or herbs by Becky Wyland, a licensed massage therapist, clinical nutritionist, clinical herbalist and personal trainer with Essential Therapy, LLC. I understand that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic.

Massage: I understand that I may also be given massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. Massage may include cupping, guasha, T-bars, and/or hot or cold packs. If I experience pain or discomfort during the session, I will immediately inform you, so that pressure/strokes can be adjusted for my level of comfort. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

I understand there are occasions when it would be inappropriate for me to receive massage. These include acute illness (fever, diarrhea, vomiting within 24 hours of scheduled appointment) and may include sub-acute illnesses, some chronic illnesses, and contagious conditions. I agree to notify you promptly of any illness or contagious condition which occurs within 24 hours before or after my scheduled appointment. If I am unsure whether or not it is appropriate to keep my scheduled appointment, I will contact you as soon as possible and/or will consult with my physician.

Herbs: I understand that herbs may be recommended to me to address bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these herbs but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these herbs. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Herbs may interact adversely with pharmaceutical medications. I will disclose all medications I am taking, including over-the-counter, and will discuss drug-herb interactions with my licensed physician or pharmacist. *Should I experience any problems which I associate with these herbs, I should suspend taking them and call Becky Wyland at 303-349-3835 as soon as possible*.

Exercise/Self-Care: Recommended exercises and self-care techniques can sometimes cause side effects, including bruising, discomfort, and the possible aggravation of symptoms existing prior to treatment. If side effects occur, I understand that I should discontinue these exercises or techniques until following-up with Becky or my physician.

I understand that Becky Wyland does not diagnose illness or disease and does not prescribe medical treatments or pharmaceuticals, nor are spinal manipulations a part of the therapy. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask Becky for a more detailed explanation. I give my permission and consent to treatment.

Patient Name (PRINT)_____ Signature_____Date_____

Legal Guardian must sign if patient is a minor. Relationship to Patient_____

NOTICE OF PRIVACY PRACTICES

We are dedicated to providing top-quality service. Protecting your privacy is paramount, and we have implemented procedures to safeguard the information included in your files. We have installed a firewall on our computer; all files and paperwork are stored electronically and can only be accessed with a password. **This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Your Personal and Protected Health Information

We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

* We may provide PHI about you to health care providers or third parties who are involved in the provision, management or coordination of your treatment care.
* We may disclose your PHI to any third party you designate in writing.
* We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
* We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
* We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
* We may disclose your PHI to a health oversight agency for activities authorized by law.
* We may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
* We may release your PHI as necessary to comply with laws relating to Workers' Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
* Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
* We may use or disclose your PHI when required by law.
* We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls/emails, recall emails, information about alternative therapies, or other related information that may be of interest to you.

Please note your rights regarding this information:

1. You are entitled to inspect and receive copies of your records.
2. You are entitled make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have the right to disagree with the practitioner's refusal of inclusion.
5. You have a right to receive all notices in writing.
6. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.
7. You may complain to us or the Secretary for Health and Human Services if you feel that we have violated your privacy rights. There will be no retaliation for filing a complaint. Written comments should be addressed to Becky Wyland at our office address or the Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

Effective Date: April 25, 2013

This notice remains in effect until it is replaced or amended by changes in the law.

_____ _____

Name (please PRINT) Date

_____

Signature