Ottawa Integrative Health Centre Inc.
1129 Carling Ave., Ottawa, ON K1Y 4G6
P: (613) 798-1000 F: (613) 798-9995 www.oihc.ca

Mayan Abdominal Therapy Intake Form

Patient Information

Name_____ Date of Initial Visit_____

Address_____

City_____ Province_____ Postal Code_____

Home Phone_____ Cell Phone_____

Work Phone_____ E-Mail_____

☐ Yes, sign me up for the monthly e-newsletter

Date of Birth *day*_____ *month*_____ *year*_____ Age_____

Occupation_____

Marital or relationship status _____

Referred By_____

Emergency Contact Information

Name_____ Relation_____

Phone_____ E-Mail_____

Other Health Care Providers

1._____ 2._____ 3._____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Client Confidentiality and Release Form

I understand that this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations (unless specified under his/her professional scope of practice). The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form for their client before taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records.

I (name) _____

Give permission for my practitioner to take notes including health history/medical and/or personal information I chose to disclose to him/her. I understand this information may be used for the purpose of practitioner certification and/or may be shared with the Arvigo Institute, LLC for statistical data collection only. All relevant identifying information will not be disclosed such as name, address, social security number, date of birth.

Client Signature: _____ Date:_____

Practitioner Signature: _____ Date: _____

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Please review and check the following:

Type of illness	PAST	PRESENT
Asthma		
Cold Hands or Feet		
Swollen ankles		
Sinus conditions Frequent colds		
Seizures		
Low back pain		
Skin disorders Type: _____		
Sciatica		
Painful or swollen joints		
High or low blood pressure		
Dentures or Partials		
Numbness in feet or legs when standing		

Type of illness	PAST	PRESENT
Varicose Veins Location:_____		
Hemorrhoids Location: _____		
Sore heels when walking		
Anxiety		
Depression		
Sleep disturbance		
Fainting spells		
Muscular Tension Location: _____		
Herniated or bulging discs		
Artificial or missing limbs		
Contact lenses		
Cancer (past or current) Which type:_____		

Family History:

Relation	Still living?	Cause of Death and Age of	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

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Digestion and Elimination

Describe a typical day's food and beverage intake

*breakfast*_____

*lunch*_____

*dinner*_____

snacks _____

What is your water intake?

Glasses - # per day: _____

What is your caffeine intake? _____

How much *alcohol* do you consume per day?

Wine - # per week: _____ Liquor - # ounces per week: _____ Beer - #glasses per week: ____

How much *tobacco* do you consume per day?

Cigarettes - # per day: _____ Cigars - # per day: _____

How much *marijuana* do you consume per day?

per day: _____ Other: _____

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 or gas or 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 _____: _____

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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 and where are you?

_____

_____

Describe your spiritual practice (ie. Do you pray?)

_____

On a scale from 1- 10 (1 being the lesser, 10 the greater), please rate yourself in each of these qualities:

Faith ____ Hope ____ Charity ____ Generosity ____ Sense of humor ____ Fear ____ Grief ___ Sense of Fun ____

Other (describe briefly) _____

What hobbies or activities provide you with pleasure and accomplishment?

_____

Please describe your exercise routine (type, frequency)

_____

What changes would you like to achieve in six months?

_____

_____

What changes would you like to achieve in one year?

_____

_____

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Female Reproductive Health History

Please encircle your method of contraception

Pills Patch Diaphragm Injection Condoms IUD Abstinence Rhythm Method Other:_____

Length of time using method _____ Last PAP Smear _____ Results _____

Are you under the treatment for Infertility? Yes or No

If yes, describe current treatment to date (IUI, IVF, etc) _____

Menstrual History Review

Age of Menses _____ What was it like for you? _____

Last Menstrual Period _____ Length of Menses _____

Are you trying to conceive? Yes or No Possibility of Pregnancy _____

Please review and check the following:

	PAST	PRESENT
Painful Periods		
Heaviness in pelvis prior to menses		
Excessive bleeding pads per hour		
Dizziness		
Water retention		
Uterine or cervical polyps		
Vaginal infection(s)		
Bladder Infection(s)		
Painful Intercourse		
Episodes of Amenorrhea how long?)		
Vaginal dryness		

	PAST	PRESENT
Irregular cycles *Early or Late*		
Dark Thick Blood: *Beginning* *End* *Both*		
Headaches or Migraine		
Bloating		
Ovulation: Painful Failure to:		
Fibroids Location (if known) _____		
Uterine Infection (s)		
Cysts Location: _____		
Urinary Incontinence		

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Female Reproductive Health History (continued)

Number of Pregnancies:____	Complications:	Miscarriages:	Terminations:
Number of Births: ____	Please indicate dates and any other details:		
Premature Births:	Spotting during pregnancy	Weak newborns at birth	Incompetent cervix

Briefly describe your experience with the following

Pregnancy: _____

Labor: _____

Birthing: _____

Post partum: _____

Maternal family history (please encircle): Infertility Fibroids Endometriosis PMS Menopause

Cancer (type) _____ Menstrual problems _____ Other _____

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

Your Birth Trauma (if known) _____

Rate your interest in sex (please encircle) High Moderate Low None Comments _____

Do you have difficulty experiencing orgasms?_____

Do you have a history of rape, trauma or incest? If so, when_____

Did you undergo counselling for this and if yes, what was this like for you?

_____

_____

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Female Reproductive Health History (continued)

Menopause

Age symptoms began: _____ Are they getting worse, better or just the same? _____

Are you on or have ever been on hormone replacement therapy? _____ If yes, how long? _____

If yes, what was the name and dose? _____

Reason for stopping (if applicable) _____

Age of Mother at menopause _____ Concerns/Experience_____

Please encircle the following symptoms that apply to you.

Hot flashes	Insomnia	Fatigue	Memory Loss
Vaginal discharge	Dry vagina	Depression	Anxiety
Irritability	Spotting	Irregular Menses	Mood swings
Flooding	Painful intercourse	Increased libido	Decreased libido
Disturbed Sleep Pattern			

Please fill in any other additional information you deem important to your practitioner in the box below:

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Male Reproductive Health History

Please check the symptoms below that apply to you:

	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 (pls. circle) *Penis* *Testicles* *Rectum*		
Frequent Bladder or kidney infections When? _____		

	PAST	PRESENT
Urinary retention		
Difficult starting or holding urine stream		
Blood or pus in urine		
Pelvic pressure		
Insatiable sex drive		
Pain or discomfort between scrotum and testicles		
Pain or discomfort in inner thighs: *Left* *Right* *Both*		
Erection (pls encircle) *Difficulty in obtaining* *Maintaining* *Painful ejaculation*		

Results of PSA (prostate specific antigen) test if knowna and date done _____

Results of sperm count (if applicable and known) and date done _____

Family History of Prostate Disease: Yes or No Type _____ Relationship _____

Family History of Cancer: Yes or No Type _____ Relationship _____

Sexually transmitted disease: Yes or No Type (if known) _____

Rate your interest in sex (please encircle) High Moderate Low None Comments _____

Do you have a history of rape, trauma or incest? If so, when_____

Did you undergo counselling for this and if yes, what was this like for you?

_____

_____

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Patient/Client Agreement Form

Each patient/client is required to read the following before treatment.

Your signature below acknowledges the following:

1. I understand that Naturopathic and other services provided at OIHC are not covered by the provincial government, yet their expenses may be covered by private insurance plans and may be tax deductible.

2. The fees and services have been clarified in advance. Payment is due at the end of each visit as the clinic does not bill insurance companies directly. Cash, cheque, Interac, Visa, and MasterCard (no other credit card) are acceptable methods of payment

3. Forty-eight hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment.

4. Items purchased are non-refundable, whether or not they have been opened.

5. I understand that natural health care is a joint responsibility between me (the patient/client) and my practitioner. Improving my lifestyle can be as important as the remedies and treatments.

6. I understand that I may contact my health care provider by phone or e-mail and that all emails will be screened by reception and forwarded to the appropriate Naturopathic doctor/practitioner.

7. I realize that integrative health care/medicine is not an isolated system and that all our health care providers welcome teamwork with NDs, MDs, DCs, RMTs, and other health practitioners.

Patient Signature_____ Date_____