The Arvigo® Techniques of Maya Abdominal Therapy
Confidential Intake Form

Date of Initial Visit_____

Name:_____Husband/Partner_____

Address_____

Post code_____ Home Phone_____

Work Phone_____Mobile_____email_____

Date of Birth_____ Age_____Occupation_____

Marital/Relationship status_____Referred by_____

Client Confidentiality and Release Form

I understand 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 she perform spinal manipulations (unless specified under 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. Regulations require all practitioners obtain a signed release form from their client *before* taking any information about them.

I, (name)_____

Should my treatment be successful I am happy for my case study to be used for testimonial purposes. I give my permission for my practitioner to take notes including health history/ medical and /or personal information I choose to disclose to her.

Client Signature: _____ Date: _____

Practitioner signature_____Date:_____

Reason For Visit

Primary reason for visit:_____

When did you start to become concerned?_____

Describe any stress 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 Historv

Are you currently under the care of another health care provider(s)?_____Reason (s)_____

_____

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:

Please review and check the following:

Headaches Type:	Past Present	Numbness in feet or legs when star	Past Present
Asthma		Sore heels when walking	
Cold Hands or feet		Anxiety	
Swollen ankles		Depression	
Sinus Conditions Frequent Colds		Sleep Disturbance	
Seizures		Fainting Spells	
Low Back Pain		Muscular Tension: Location:	
Skin Disorders: Type		Varicose Veins Hemorrhoids Location	
Sciatica		Herniated/Bulging Discs	
Painful/Swollen Joints		Artifical/Missing limbs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Cancer (past or current) Type	

Are there any genetic illnesses in your family ? _____

_____

Have either of you had any childhood illnesses (measles , mumps, etc)_____

_____

_____

Gastroinstestinal Health History

Describe your typical:

Breakfast:_____

Lunch:_____

Dinner:_____

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?_____

Food Allergies?_____Describe_____

How often are your bowel movements?_____Do your stools: sink_____float_____

Constipation?_____Blood in stool ?_____Mucus in stool?_____Pain when stooling?_____

Diarrhea?_____Other?_____

Lifestyle, Emotional & Spiritual

What is your opinion of yourself?_____

Describe the most positive emotion you experience_____

When and Where do you experience this emotion?_____

Describe the most negative emotion you experience_____

When and Where do you experience this emotion?_____

Describe your Spiritual and/or Religious practice:_____

On a scale of 1 – 10 *(1 being the lesser, 10 the greater*) Please rate yourself in each of these qualities:

Hope____ _____Generosity_____ Sense of Humour_____Fear_____Grief_____

What hobbies/ activities provide you with pleasure and accomplishment _____

Describe your exercise routine (type, frequency)_____

What changes would you like to achieve in 6 months:_____

One Year**:**_____

Do you smoke?_____ Quantity_____ Alcohol?_____Quantity_____ounces/ day

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

Female Reproductive Health History

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method Fertility Awareness Other:_____Length of time using method_____Last smear____Results _____

Are you now or in the past experiencing Fertility Challenges? Yes___No___Describe your treatment :_____

(IUI, IVF,etc)_____

Menstrual History Review and check as indicated:

What age did your periods start?:_____What was this like for you_____ (emotionally/physically)

Last Menstrual Period:_____Length of Menses_____

Are you trying to Conceive? Yes_____No_____ Are you Pregnant? Yes____No____Unsure____

Painful Periods	Past Present	Irregular cycles Early Late	Past Present
Heaviness in Pelvis prior to period Bloating		Dark Thick Blood at: Beginning End Both	
Excessive Bleeding Pads per Hour		Headache or Migraine with menses	
Dizziness		Vaginal Dryness	
Water Retention		Ovulation: Painful Failure to	
Endometriosis Location (if known)		Fibroids Location (if known)	
Uterine or Cervical Polyps		Uterine Infection(s)	
Vaginal Infection(s)		Cysts Location:	
Bladder Infection(s)		Urinary Incontinence	
Painful Intercourse		Have you had Chlamydia Or any sexual diseases ?	
Any time when your periods stopped? How long?			

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced any emotional trauma? Yes___No____Describe_____

Did you undergo counseling for this_____

What was this like for you_____

Pregnancy History

Number of Pregnancies:_____Dates_____Miscarriage(s)_____Dates_____Termination(s)_____Dates:_____

Number of Births:_____ Dates:_____

Complications for any of the above, describe:_____

Premature Births?_____ Spotting During Pregnancy? _____Weak Newborns? _____Incompetent Cervix? _____

Describe your experience with:

Pregnancy:_____

Labor:_____

Birthing_____

Post Partum:_____

Maternal Family History of (*please circle*) 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) _____

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 flushes	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	Palpitations	Dizziness	

Additional Information you feel important your practitioner should know that is not mentioned here:

Male Reproductive Health History

Please check the symptoms below that apply

Painful Urination	Past Present	Urinary Retention	Past Present
Urinary Incontinence or Dribbling		Difficult starting or holding urine stream	
Weak or Interrupted Urine flow		Blood or pus in urine	
Pain or Burning with Urination		Pelvic pressure	
Nocturnal Urination How many times?		Insatiable sex drive	
Pain in lower back, esp After intercourse		Pain or Discomfort Between scrotum and Testicles	
Pain or Discomfort in: Penis Testicles Rectum		Pain or Discomfort in Inner thighs: Left Right Both	
Frequent Bladder or Kidney Infections When?		Erection: Difficulty in Obtaining Maintaining Painful ejaculation	

Results of PSA (prostate specific antigen) Test if known_____ Date done_____

Results of Sperm count (if applicable and known)_____Date done_____

Family History of Prostate Disease/cancer: Yes___No___Type_____Relationship_____

Sexually transmitted disease Yes___ No___ Type if Known_____

Rate your interest in Sex: High_____Moderate_____Low_____None_____

Do you have a history of trauma: describe _____

Did you undergo counseling for this _____

What was this like for you _____

Additional Comments:

ARVIGO THERAPY SELF CARE MASSAGE TECHNIQUES

All the self care techniques are therapeutic, applied only to yourself, and intended for use in conjunction with treatments that you will receive from a trained Arvigo practitioner. These techniques provide benefit to both women and men.

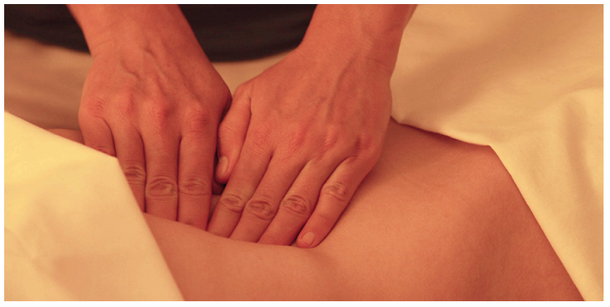
Self care techniques for men and women encourage the abdominal organs into proper position and improve flow of blood, lymph, nerve impulses, and ch'ulel. Proper positioning and improved flow enhance your body's natural healing abilities and bring balance to the upper and lower abdomen. Self care techniques are for you to use in conjunction with treatments from an Arvigo practitioner. **Regular self care at home is very important to enhance the treatment benefit**. This handout reinforces what your practitioner taught you during your session. Your practitioner may give you some supplementary guidance, which you should record in the "Notes" section at the end.

Preparation

- Empty your bladder.
- Create a quiet place to relax for five to ten minutes.
- Perform self care through loose clothing, a sheet, or on bare skin with or without oil.
- Lie on your back and place pillows under your head and your knees (if desired).
- Elevate your hips by placing a pillow under your pelvis if you have a prolapse.

Note: Breath is important. For best results, stroke when you exhale.

Lower Abdomen Pelvis Massage

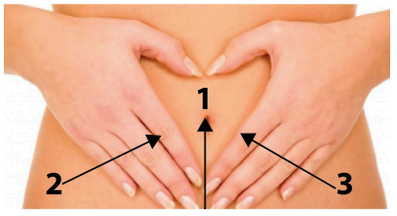


There are three positions: center, right, and left sides.

Center Position:

- Bring your hands together with fingers together, slightly bent and relaxed. (See the illustration on left.)
- Place your fingers on the indent where the pubic bones meet in the middle of your pelvis, with palms gently resting on your belly.
- Slide your fingers off the pubic bone onto the soft tissue of your belly.

Lower Abs
30 strokes



- Apply comfortable pressure into the soft tissue and with consistent pressure, slowly move your fingertips toward your navel, stopping halfway between the pubic bone and navel.
- **Lift your hands** and return them to the pubic bone indent and repeat the stroke.
- Do this a total of three times.

Side Position(s):

- Move to the right or left side of your pelvis to feel another small indent where the hip and pelvic bones meet. Place your fingers here to begin your side strokes.
- Keeping fingers together, slightly bent and relaxed, slide off the bone and apply comfortable pressure into the soft tissue space of the lower abdomen. Maintain consistent pressure while you slowly stroke toward the navel. Stop at the same place you did for the center position.

- Perform this stroke three times.
- Now move to the other side of your pelvis and repeat the side strokes there on your lower abdomen.
- Return to the indent in the center of the pelvis, where you began, and repeat the entire process for two more rounds.

Finish the lower abdomen work with three strokes up the center for a total of thirty strokes.

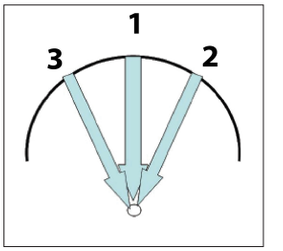
Note: A woman with a properly positioned uterus will feel a deep, open space above the pubic bone and a similar amount of open space on each side of the lower abdomen.

Upper Abdomen Massage

As with the lower abdomen, there are three positions: center and two sides.

Curl your fingers, bringing the backs of your hands to form the "Maya M."

Upper Abs
30 strokes



Center Position:

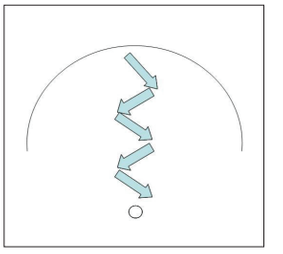
Place your fingertips just below your breastbone and move slowly and firmly to your navel (working with your breath).

Perform this stroke three times.

Side Positions:

- Begin with the "M" hand position on one side of your upper abdomen just below your rib cage.
- Stroke your fingertips diagonally toward your navel x 3.
- Repeat on the other side of your upper abdomen x 3.
- Return to center.
- Repeat entire process twice more for a total of thirty strokes.

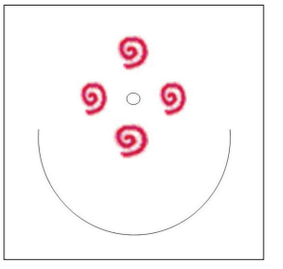
Zigzags
(down and up)



Zigzags:

- Begin in the center just below the breastbone.
- Applying comfortable pressure, gently and slowly massage with a zigzag stroke down to just above your navel.
- Zigzag back to the sternum with lighter pressure.
- Perform this stroke three times.

Gardening for Potatoes
Keyhole



Keyhole:

- Massage with deep circles around your navel.
- Work in a clockwise direction.
- Spend as much time here as comfortable.
- You don't have to work out all the tension at one time.

Note: Hand positions vary where tension is present.

Lymphatic Strokes

Upper Abdomen:

- Apply a light touch with hands and fingers flat on your skin, about the weight of a 5p coin
- Make small sweeping motions between your ribs a little below your breastbone. #
- Place one hand on either side of your pelvis just above your hips; make light, sweeping motions.
- Move up the center of your body toward your heart, continuing with sets of sweeping motions. Begin each set lower on your legs.

- The final set starts on your legs as far as you can comfortably reach.
- Movements are from the sides of the legs upward to the center and your heart.

Note: Spend extra time over the lymph glands where your groin meets your thighs if needed.

Closing the Gate

Closing the Gate:

Hand position: spiral out and spiral in.

- Using both hands together, flat on your abdomen, spiral lightly around your navel in a clockwise direction.
- As you progress, make your spiral bigger and bigger, reaching the sides of your abdomen, bottom of your ribs, and top of your pubis.
- Keeping the clockwise direction, gradually close the spiral, getting smaller and smaller, until your hands are resting on your navel.
- Perform this stroke three times.

After Self Care

Drink plenty of water. Good hydration supports the healing process.

Honor your experience. Reflect on any changes you note, responding as necessary to gain the most benefit from your experience.

As you gain experience with self care, seek a balance between comfortable pressure and relaxed hands. If thumbs or little fingers stick out rigidly, relax your hands a little more. Some people find that resting their elbows on the bed for some of the strokes helps relax their hands more. As you feel comfortable with self care, consider varying things a bit, paying attention to whether doing so improves your result. If not, go back to the standard routine above.

Cautions: Following the guidance of a qualified practitioner to practice these techniques is safe, but there are times when they should be either modified or discontinued altogether. Be aware of the following cautions and, as always, consult your practitioner if you have questions.

Periods: During and five days prior to period do not **deeply** massage the uterus. You may massage over the groin and upper abdomen. During menses, it may be helpful to apply gentle and superficial massage over the uterus.

Pregnancy: Do not perform the lower abdominal or lymphatic work during the first twenty weeks of pregnancy. Self care massage can be adapted after the twentieth week of pregnancy. Consult with your practitioner for Pregnancy Self Care Guidelines.

Abdominal Surgery: Abdominal surgery typically requires from six to eight weeks for tissue to fully heal after the procedure. Consult with your physician or primary health care provider to determine when you are able to perform or receive abdominal massage.

Medications: Pain medications or other substances may mask your response to this modality.

Intrauterine Device: Do not perform self care if you have an IUD (intrauterine device) in place.

Acute Pain or Infection: Do not perform self care if you have acute abdominal/pelvic pain or infection.

Emotional Releases: Emotional response may occur during self care. Your practitioner is available to support you and refer you for professional support if indicated.

Intense Pain: If your self care massage appears to generate intense abdominal pain or discomfort, then stop the massage immediately and inform your practitioner or seek medical intervention.

Pessary: If you have a pessary in place, remove it prior to self care massage.

Gastroesophageal Reflux Disorder (GERD) or Hiatal Hernia: If either of these conditions is present, proceed slowly with light pressure.

Hernia Repair: If you have had a hernia repair, consult with your Arvigo practitioner before massaging over the repaired area.

Fertility Technology: You should discontinue self care if you are pursuing fertility enhancement through a method of assisted reproductive technology after implantation.

Notes: