Mayan Abdominal Therapy (MAT) for Men

Embody Genesis

Date of Initial Visit: _____

Name: _____ Occupation: _____

Address_____ City: _____

State: _____ Zip: _____ Home phone: _____

Cell phone: _____ E-mail: _____

Date of birth: _____ Age: _____

Marital/relationship status: _____

Referred by: _____

Client Confidentiality and Release Form

Confidentially of medical and personal information obtain during the course of the practitioner's work is of the utmost importance and will not be shared. I understand this modality is not a replacement for medical care. The practitioner may be referred to a qualified health professional for any physical or emotional condition. I have stated all my known conditions and taken upon myself to keep the therapist updated on my health

Client signature: _____ Date: _____

Reason for Visit

Primary reason(s) for visit: _____

When did you first notice it? _____

What brought it on? _____

Describe any stressors occurring at the time? _____

_____

What activities provide relief? _____

What makes it worse? _____

Does this condition interfere with: ☐ Work ☐ Sleep ☐ Recreation

Have you had massage/bodywork before? ☐ Yes ☐ No

What type of massage/bodywork? _____

Medical History

Are you currently under the care of another health care practitioner? ☐ Yes ☐ No

Name(s) of Practitioner: _____

_____

Reason(s) for care: _____

Medications: _____

Allergies (allergen and reaction): _____

_____

Surgical history (year and type) and/or recent procedures: _____

_____

_____

Hospitalizations (year and reason): _____

_____

_____

Accidents or traumas (year and type): _____

_____

_____

Falls/injuries to sacrum, head, and/or tailbone (describe): _____

_____

_____

_____

Digestion and Elimination

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____

Water intake (glasses/day): _____ Caffeine (glasses/day): _____

Drug and Alcohol Use

Tobacco: ☐ Yes quantity per day _____ ☐ No

Alcohol: ☐ Yes quantity per day _____ ☐ No

Marijuana: ☐ Yes quantity per day _____ ☐ No

Other: ☐ Yes description_____quantity per day _____ ☐ No

Have you been under treatment for substance use: ☐ Yes ☐ No

What is the worst item in your diet: _____

What foods are your weakness: _____

Are you subject to binge eating? ☐ Yes ☐ No What foods?_____

_____

Do you experience bloating/gas/burps after eating? ☐ Yes ☐ No

What foods trigger this? _____

How often are your bowel movements? _____

Do your stools: ☐ Sink ☐ Float

Do you experience (check all that apply_:

☐ Constipation ☐ Blood in stool ☐ Mucus in stool ☐ Pain when stooling

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 to 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_____

What hobbies/ activities provide you with pleasure and sense of accomplishment: _____

_____

Describe your exercise routine (type, frequency): _____

_____

What changes would you like to achieve in

6 months: _____

One year: _____

Check all that apply:

Headaches:	☐ Past	☐ Now	Numbness in feet/legs	☐ Past	☐ Now
Asthma:	☐ Past	☐ Now	Sore heels when walking:	☐ Past	☐ Now
Cold hands or feet:	☐ Past	☐ Now	Anxiety:	☐ Past	☐ Now
Swollen ankles:	☐ Past	☐ Now	Depression:	☐ Past	☐ Now
Sciatica:	☐ Past	☐ Now	Sleep disturbance:	☐ Past	☐ Now
Seizures:	☐ Past	☐ Now	Fainting spells:	☐ Past	☐ Now
Low back pain:	☐ Past	☐ Now	Varicose veins:	☐ Past	☐ Now
Frequent colds or sinus condition:	☐ Past	☐ Now	Muscular tension (where): _____	☐ Past	☐ Now
Dentures/partials:	☐ Past	☐ Now	Herniated/bulging discs:	☐ Past	☐ Now
Painful/swollen joints:	☐ Past	☐ Now	Hemorrhoids:	☐ Past	☐ Now
High blood pressure:	☐ Past	☐ Now	Low blood pressure:	☐ Past	☐ Now
Skin disorders (explain): _____	☐ Past	☐ Now	Cancer (describe): _____	☐ Past	☐ Now

Family History

	Major health issues	Still living?	Cause of death
Mother:	_____	☐ Yes ☐ No	_____
Father:	_____	☐ Yes ☐ No	_____
Siblings:	_____	☐ Yes ☐ No	_____
Maternal grandmother:	_____	☐ Yes ☐ No	_____
Paternal grandmother:	_____	☐ Yes ☐ No	_____
Maternal grandfather:	_____	☐ Yes ☐ No	_____
Paternal grandfather:	_____	☐ Yes ☐ No	_____

Male Reproductive Health History

Check all that apply:

Urinary incontinence or dribbling:	☐ Past	☐ Now	Difficulty starting holding or urinary stream:	☐ Past	☐ Now
Weak/interrupted urination:	☐ Past	☐ Now	Blood or pus in urine:	☐ Past	☐ Now
Burning urination:	☐ Past	☐ Now	Pelvic pressure:	☐ Past	☐ Now
Nocturnal urination:	☐ Past	☐ Now	Insatiable sex drive:	☐ Past	☐ Now
Pain in lower back/spasm after intercourse:	☐ Past	☐ Now	Pain or discomfort between scrotum and testicles	☐ Past	☐ Now
Pain or discomfort in penis:	☐ Past	☐ Now	Discomfort in left inner thigh	☐ Past	☐ Now
Pain or discomfort in testicles:	☐ Past	☐ Now	Discomfort in right inner thigh	☐ Past	☐ Now
Pain or discomfort in rectum:	☐ Past	☐ Now	Discomfort in both inner thighs	☐ Past	☐ Now
Frequent bladder infections:	☐ Past	☐ Now	Difficult obtaining erection	☐ Past	☐ Now
Frequent kidney infections:	☐ Past	☐ Now	Difficulty maintaining erection	☐ Past	☐ Now
			Painful ejaculation	☐ Past	☐ Now

Results of PSA (Prostate Specific Antigen) test (if known): _____

_____ Date done: _____

Results of sperm count (if known): _____

_____ Date done: _____

Family history of prostate disease: ☐ Yes ☐ No Type: _____

Relationship: _____

Family history of cancer: ☐ Yes ☐ No Type: _____

Relationship: _____

Sexual transmitted disease: ☐ Yes ☐ No Type: _____

Rate your interest in intercourse: ☐ High ☐ Moderate ☐ Low ☐ None

Do you have a history of: ☐ Rape ☐ Trauma ☐ Incest

If so, when? _____

Did you undergo counseling for this: ☐ Yes ☐ No

What was this like for you? _____

_____

Additional comments: _____

_____

_____

_____

_____