



LYMPHATIC THERAPY INTAKE FORM

Name: _____ Male Female Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

How did you hear about us? _____

Emergency Contact, Name & Phone: _____

General Medical Information

Have you received massage therapy or bodywork before? Yes No

If yes, what kind and how recently was it? _____

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

- High Blood Pressure, Pregnant, Contagious Conditions, Contact Lens, Low Back Pain, Allergy to Nut Oils, Osteoporosis, Diabetes, Blood Clots, -If current, what trimester?, Low Blood Pressure, Varicose Veins, Bursitis, Skin Infections, Hypo or Hyperglycemia, Muscle Sprain / Strain, Heart Attack / Stroke, Arthritis, Headaches, Congestive Heart Failure, Unexplained Calf Pain

Please list and explain other conditions/symptoms you had or are having that concern you: _____

Have you had any serious or chronic illnesses? If yes, please list _____

Operations? Traumatic accident(s)? If yes, please list _____

Do you have any implanted electronic devices in your body: pacemaker, ICD, Medicine pumps? Yes No

Metal implants and/or joint replacements? Yes No If yes, please list _____

Are you currently, or have you at any time within the last 12 months been under the care of a physician? Yes No

If yes, for what condition(s)? _____

Do I have your permission to contact your Doctor? Yes No

If yes, Doctor's Name: _____ Phone # _____

Are you on any medication? Yes No If yes, please list _____

Are you taking any herbs or supplements daily? Yes No If yes, please list _____

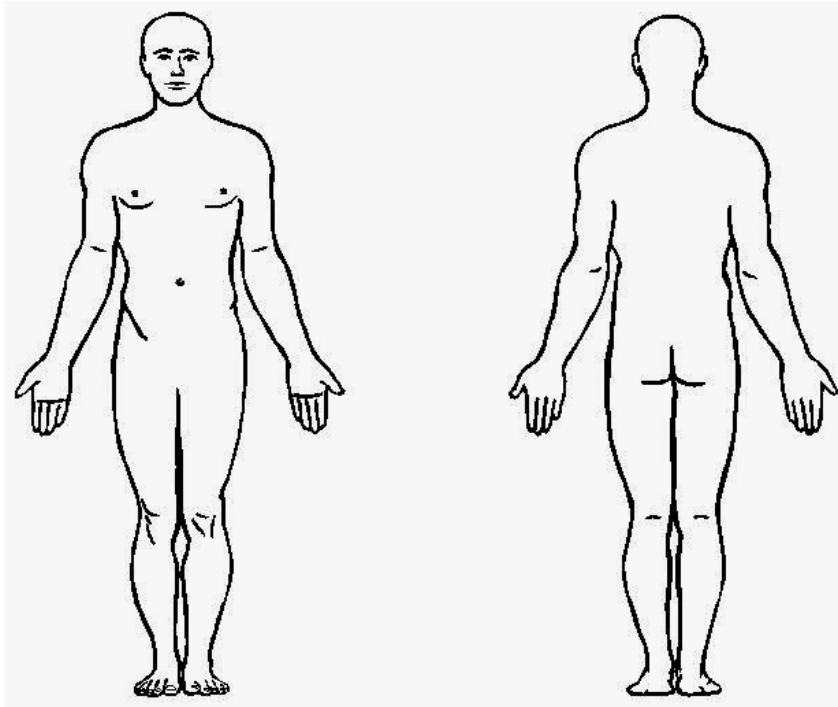
Have you ever had any electronic lymphatic therapy prior to this visit? Yes No If yes, when? _____

I have completed this health form to the best of my knowledge. I understand that Massage Therapy, Bodywork, and Lymphatic Manual technique services are a therapeutic health aid and are non-sexual. They do not take the place of a physician's care when indicated. Any information exchanged during a Massage, or Bodywork such as, session is confidential and is only used to provide me with the best health care services.

I have been given instructions by the therapist into the possible detoxification (cleansing effects) of lymphatic (Lymphstar Pro) and photonic therapies (Eclipse, Infrared Radiance, Blue Radiance). I understand that such effects may be of concern for one or three days following the therapy and that I will call the therapist during business hours if I have any concerns after my therapy session.

If I cancel, reschedule, or skip an appointment without 24-hour notice, I agree to pay for the total amount of the treatment.

Client Signature _____ Date _____



Anatomy covered:

Terminus
Breast
Cisterna Chyli
Iliac nodes
Popliteal nodes

Axillary nodes
Parasternal
Abdomen/Colon
Inguinal nodes
Back

LP Frequency:

Notes: