



Patient Information - Lymphatic Massage Therapy

Name: _____ Date of Birth: ____/____/____

Occupation: _____ Phone: _____

Email: _____

How did you find us? _____

Are you currently under the doctor's care? Yes/No If so, why? _____

Do you take any medication? If yes, which ones? _____

Do you have any allergies towards scented/unscented oils, lotions or creams? Yes/No If yes, please specify _____

Cancer: Type? _____

Surgeries: Which one and when? _____

Please circle if you suffer from any of the following:

Severe Anemia/Asthma/ Allergies/ Diabetes/ Headaches/ Chronic Fatigue/ Aneurysm/ Heart Trouble/ Circulatory/ Respiratory/ High Blood Pressure/ Thrombosis

Pulse rate: _____ Blood pressure: Low/Normal/High Cholesterol: Low/Normal/High

If female, are you pregnant? Yes/No If yes, how many weeks? _____

Have you ever had a Lymphatic Massage? Yes/No Last series? _____

Results? _____

Do you use any of the following and how often do you use them?

Cigarettes _____ Alcohol _____

Do you exercise? Yes/No How often? _____

In case of an emergency, whom should we call? Phone: _____

Relationship: _____ Name: _____

It is my choice to receive Lymphatic Massage. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, detoxification of the body, against cellulite, pain, or for increasing circulation and energy flow. I agree to communicate with my practitioner anytime I feel like my well-being is being compromised. I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatments, pharmaceuticals, or perform spinal thrust manipulations. I undersigned, hereby acknowledge that my therapist has not, is not and will not prescribe, (order for use as medicine) for me at any time and I, the undersigned, will not hold them accountable for such.

Signature _____ Date: _____

Notes:

