Lymphatic Massage Works Client Information

Welcome! Thank you for taking the time to fill out this form.
All information will be kept confidential.

Name: _____ ❑Home phone: _____

Address: _____ ❑Work phone: _____

City _____ State _____ Zip _____ ❑Cell phone: _____
(check preferred phone)

Email: _____ Age: _____

Occupation: _____ How did you find Lymphatic Massage Works? _____

Primary reason for appointment: _____

Have you received professional massage before? ❑ yes ❑ no Favorite style/technique: _____

Do you exercise? ❑ yes ❑ no How often? _____ What type? _____

Are you currently under the care of a physician? If yes, please describe: _____

_____ Physician contact: _____

Are you taking any medications? If yes, please list with condition(s): _____

_____

Have you had any major surgeries or injuries? If yes, please list with dates: _____

_____

Are you pregnant? If yes, how many weeks? _____ Allergies to nuts, oils or lotions? ❑ yes ❑ no

Please check if you have or have a history of any of the following:

❑ Arthritis	❑ Seasonal allergies	❑ Cancer *(please complete oncology form)*
❑ Disc problems	❑ Sinus problems	❑ Heart condition
❑ Bone pins or spinal rods	❑ Hyperthyroidism	❑ Lymphedema Location: _____
❑ Muscle or joint problems	❑ Diabetes	❑ Poor circulation
❑ high/low blood pressure	❑ Fibromyalgia	❑ Blood clots
❑ Chronic pain/tension	❑ Headaches ❑ tension ❑ migraine	❑ Varicose veins

Please elaborate on any item checked: _____

_____

Is there any condition not listed above that your massage practitioner should be aware of? If yes, please list

_____

I, the undersigned, understand that massage therapy and manual lymph drainage are for the purpose of stress reduction, relief from muscle tension pain, relaxation and improvement of circulation and lymphatic flow. I am aware that my massage practitioner does not diagnose health conditions, prescribe medication or perform spinal manipulations. I understand professional massage is not a substitute for medical treatment by a doctor. I understand I may terminate a massage session at any time if I feel uncomfortable with the course of treatment. Therapist reserves the right to end session in the case of any inappropriate behavior. The benefits of massage therapy and its contraindications have been explained to me and I affirm I have stated all known medical conditions and agree to inform my practitioner of any changes to my health. I hereby assume full responsibility for the receipt of massage therapy and release the Therapist from all claims, liabilities or damages arising from the therapy received.

Client Signature _____ Date _____

Would you like to receive an occasional e-newsletter from Lymphatic Massage Works? ❑ yes ❑ no