LYMPHATIC ENHANCEMENT THERAPY
CLIENT INTAKE FORM

Name:_____

Address:_____

State:_____Zip:_____Email:_____

Phone: Cell:_____Home:_____

Date of Birth:_____Occupation:_____

Referred By:_____

Emergency Contact:_____Phone:_____

Reason for seeking Lymphatic Enhancement Therapy:

Do you currently have any of the following conditions? Please circle:
Congestive Heart Failure Renal Failure Blood Clot Pacemaker
Open Wound Cancer Stroke

Please circle any items you are currently wearing:

Contact lenses/ Pacemaker/ Hearing Aid/ Hairpiece/ Other:_____

Consent for Care:
I understand that Lymphatic Enhancement Therapy is for improving lymphatic flow and circulation. I have stated all of my known medical information and understand that it is my responsibility to keep my Lymphatic Enhancement Practitioner informed of any changes in my health and of any medications I may take in the future. I also understand that Lymphatic Enhancement Therapy is not a substitute for medical treatment and that I should see a doctor/health care provider for diagnosis and treatment for any suspected medical problem.

Signature:_____ Date:_____

Please continue on side 2 →

MEDICAL HISTORY (Circle any of the following that apply and indicate if any are current)

Skin Conditions:
Boils Fungal Infections (Athlete's foot, ringworm,etc) Herpes Warts Botox/Fillers
Eczema Hives Moles Psoriasis Skin Cancer Allergies:_____

Respiratory Conditions:
Bronchitis Cold Influenza Pneumonia Sinusitis Tuberculosis Asthma
Emphysema Lung Cancer Chronic Cough Allergies:_____

Endocrine System Conditions:
Diabetes Hyperthyroidism Hypothyroidism Hypoglycemia

Musculoskeletal Conditions:
Fibromyalgia Sprains/Strains Osteoporosis Gout Carpal Tunnel
Lyme Disease Osteoarthritis Rheumatoid Arthritis Whiplash Herniated Disc

Reproductive System Conditions:
Cervical Cancer Endometriosis Fibroid Tumors Breast Cancer Ovarian Cancer
Prostate Cancer Pelvic Inflammatory Disease Pregnancy PMS

Nervous System Conditions:
Multiple Sclerosis Parkinson's Bell's Palsy Spinal Cord Injury Stroke Seizures

Headaches: Migraine Tension Cluster PMS

Digestive System Conditions:
Indigestion Constipation Diarrhea Reflux Disorder Stomach Cancer Ulcers
Appendicitis Colorectal Cancer IBS Ulcerative Colitis Hepatitis Gallstones

Circulatory System Conditions:
Anemia Blood Clot Hematoma Leukemia Clotting or bleeding problems
Atherosclerosis Hypertension (HBP) Low Blood Pressure Varicose Veins

Lymph & Immune System Conditions:
Edema Lymphoedema Chronic Fatigue Syndrome Fever HIV/AIDS
Lupus Epstein Barr (Glandular Fever)

Urinary System Conditions:
Kidney Stones Urinary Tract Infection (UTI) Bladder Cancer

Other condition(s) not listed above:_____
Do you have any contagious skin conditions: No/Yes:_____

Please list ALL surgeries :

Please list current medications/vitamins/supplements: