CLIENT INTAKE FORM – LYMPHATIC ENHANCEMENT THERAPY (LET)

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve)_____
Address _____
City/State/Zip _____ Email _____
Date of Birth _____ Occupation _____
Emergency Contact _____ Phone _____
How did you hear about us?_____

1. Have you had a professional massage before? **Yes No** If yes, how often do you receive massage therapy? _____
2. Do you experience sensitivity to scents/aromas? **Yes No** If Yes, please explain _____
3. Do you have sensitive skin or allergic reactions on the skin? **Yes No** If Yes, please explain _____
4. Do you sit for long hours at a workstation, computer or driving? **Yes No**
   ⇒ If yes, please describe _____
5. Do you perform any repetitive movement in your work, sports or hobby? **Yes No**
   ⇒ If yes, please describe _____
6. Do you experience stress in your work, family or other aspects of your life? **Yes No** If yes, does it show up in any of these ways?

   ( ) muscle tension ( ) anxiety ( ) insomnia ( ) irritability

7. Do you exercise regularly? **Yes No**
   ⇒ If yes, what type? _____How often?_____
8. How much water do you drink daily? _____ 9. Do you smoke? **Yes No**
9. How would you describe your digestion? _____

Medical History:

1. Have you **ever** been treated for cancer? **Yes No** What type? _____When? _____
   ⇒ If yes, did you have radiation or chemo? **Yes No** When? _____How Long? _____
   ⇒ Did this treatment involve the removal, radiation or testing of lymph nodes? **Yes No**
   ⇒ Do you know how many? _____ From what area(s) of the body? _____

2. Please list any condition(s) that you are now experiencing or have had in the past that are causing you concern:

1.	5.
2.	6.
3.	7.
4.	8.

THE FOLLOWING CONDITIONS ARE CONTRAINDICATED FOR LYMPHATIC ENHANCEMENT THERAPY and MAY REQUIRE AUTHORIZATION FROM YOUR MEDICAL PROFESSIONAL BEFORE TREATMENTS CAN BE PERFORMED.
PLEASE INDICATE "Y" OR "N" FOR EACH OF THE FOLLOWING:

Implanted electrical device	Cancer, currently being treated	Deep vein thrombosis/blood clots/ Phlebitis
Pregnancy	Congestive Heart Failure or Stroke	Open sores or wounds
Current Fever	Recent Surgery	Circulation/cardiovascular disorder

3. Do you have breast implants? **Yes No** If yes, what year were they implanted? _____ Year explanted? _____
4. Have you recently had injectables such as Botox, Juvéderm or fillers? **Yes No** If yes, when? _____

5. Please list all medications and/or supplements you are currently taking and list the condition(s) for which you are taking it.

Medication/Condition	Medication/Condition
/	/
/	/
/	/

6. What are your goals for this session? _____
   ⇒ Future sessions? _____

Privacy Policy: All written records and massage sessions are kept strictly confidential and will not be shared with any outside persons, establishment, organizations or medical facilities without explicit written consent from the client (you) or the client's legal guardian, unless legally required by local, state or federal subpoena, summons or other court order.

Authorization to communicate with client's health team (Optional): By initialing where indicated, I hereby authorize Professional Lymphatic Therapy to communicate directly with the following health care professionals as it relates to my healthcare.

_____	_____	_____
Health Care Professional's Name	Phone and/or email address	Client Initials
_____	_____	_____
Health Care Professional's Name	Phone and/or email address	Client Initials

Informed Consent, Client Agreement and Hold Harmless:

♦ You have the right to a competent, client-centered treatment and are encouraged to communicate openly with your therapist throughout the session about your questions, goals, comfort level. ♦ You understand that the treatments we provide are not a substitute for medical care and that it is recommended you work with your primary caregiver for any condition or concerns you may have prior to beginning treatments. ♦ LMT's do not diagnose, provide medical advice or guarantee any type of specific results. ♦ LMTs in this facility do NOT interact with external fluid in any way; Lymphatic Drainage refers to assisting the internal flow of lymphatic fluid within the vessels. ♦ **Cancellations should be communicated to the therapist at least 24 hours in advance of scheduled appointment to avoid paying a full fee for the missed session**. ♦ Late arrivals may result in a shortened session; full fee remains due. ♦ Any type of sexual misconduct or indication of being impaired by alcohol or drugs will be grounds for immediate termination of the therapy session and all fees remain due. **It is the Client's Responsibility** to keep therapist informed of changes in health status, medications and any known contraindications. **Draping Policy:** We require full draping at this facility. Possible exceptions are noted below; client must authorize with signature.

I. However, due to the nature of lymphatic work, there will be times when breast tissue will be revealed – one breast at a time – to facilitate the flow of the lymph fluid towards the terminus and/or axillary nodes. Do we have your permission to work on or around the breasts? **INITIAL HERE IF YES _____ or circle NO. PLEASE NOTE THAT WE DO NOT COME IN CONTACT WITH THE NIPPLES NOR DO WE OFFER BREAST MASSAGE AT THIS FACILITY.**
II. _____ (Initial Here, if applicable) I have just had surgery and my incision sites/inflammation/current condition/comfort level prevent me from utilizing the draping provided. I authorize PLT, LLC to perform lymphatic therapies to the affected areas with or without draping. Affected areas may include face, neck, terminus, axillary, arms, hands, lateral breasts, sternum, abdomen, back, waist, hips, lateral glutes, legs, ankles and feet. **AREAS NEVER TO BE TREATED INCLUDE MEDIAL UPPER THIGHS, MEDIAL GLUTES, GENITILIA AND NIPPLES OR ANY OTHER AREA THAT CLIENT REQUESTS TO BE AVOIDED, AS NOTED HERE:**
    a. _____

I am voluntarily agreeing to the treatment recommended by my LMT, which may include the use of a medical device (Lymphstar ProFusion or the like). Further, I have completed the Client Intake Form completely, thoroughly, honestly and have revealed & discussed any and all health issues, especially the ones that would contraindicate the use of said device.

☐ I want to hear about exclusive specials, updates, workshops & offerings by Professional Lymphatic Therapy & Wellness

Client Signature _____ Date _____