PROVENCE
WELLNESS CENTER

LYMPHATIC THERAPY IN-TAKE 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	**–If current, what trimester?**	☐ Muscle Sprain / Strain
☐ Low Back Pain	☐ Low Blood Pressure	☐ Heart Attack / Stroke
☐ Allergy to Nut Oils	☐ Varicose Veins	☐ Arthritis
☐ Osteoporosis	☐ Bursitis	☐ Headaches
☐ Diabetes	☐ **Skin Infections**	☐ **Congestive Heart Failure**
☐ **Blood Clots**	☐ Hypo or Hyperglycemia	☐ **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 _____