Sarah Gardon

Lymphatic Therapy

Confidential Client Information and Health History

First Name_____ Last_____
Address_____
City_____
State_____ Zip_____ Phone_____
Birth Date:____/____/_____
Email Address:_____
Occupation:_____
Emergency Contact:_____ Phone:_____
Relationship:_____
Primary healthcare professional:_____
Referred by:_____

Please take a moment to carefully complete the following information and sign where indicated. If you have a specific medical condition, or specific symptoms, therapy may be contraindicated. A referral from your primary care physician may be required.

Do you have a heart condition?_____
Are you currently taking immunosuppressant medication?_____

What would you like to focus on in our session today?

_____

_____

Describe any surgeries, hospitalizations, accidents, major illnesses, or injuries you have had (include dates). For recent surgeries (within 6 months), please note the name of your surgeon and facility where the surgery took place.

_____

_____

_____
_____
_____

Do you have any chronic pain?_____ Please Explain_____
_____

Please list any medications taken now or at regular intervals. Include an explanation of what the medication is used to treat_____
_____
_____

Have you been exposed to a high level of environmental toxins (eg. worked as a fireman, in a nail salon, etc)? If so, please describe _____

Is there anything else you would like to tell me about your health, past or present-physical history, stressful events... that you would like to bring into our work together?
_____
_____

*For women:
Any breast discomfort, with menstruation or any time?_____
_____
Cysts/fibrotic tissue?_____
Are you currently, or have you breastfed a child? If so, how long? _____
Do you have an IUD?_____

In working to support your breast health, please know that your comfort and emotional empowerment is very important to me. A lot can be achieved with full draping maintained, although it can be more beneficial to worlk directly on the breasts. If you ever notice yourself feeling off-center, or uncomfortable in any way, or would simply like to take a pause, please honor your feelings in the moment, and let me know that we need to make a change. If words don't come, just raise your hand and trust that we'll figure out what's next.*

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medicines or manipulate bones. I further understand that massage therapy is not a substitute for medical examination. I take full responsibility for alerting my practitioner to any changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (emergencies excluded) will be charged half the cost of the missed session.

Signature_____ Date_____
Consent to treatment of minor:
Signature of parent or guardian_____
Date_____ Relationship to
client_____