# Georgetown Lymphatic Massage - Laurel West, LMT # 116125

## Manual Therapy Client Intake Form

Name:_____DOB:_____
Address:_____
City:_____State:_____Zip:_____Phone:(___)_____
E-mail:_____
Referred by:_____Phone:(___)_____
Physician and/or Surgeon:_____
Client Occupation:_____Circle: Male Female
In case of emergency: _____Phone (___)_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, manual therapy/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional manual therapy and/or bodywork session? YES NO
What are your bodywork goals?_____
What is your current level of pain on a scale of 0<10? (Least < Most) Circle: 0 1 2 3 4 5 6 7 8 9 10

Yes No Do you frequently suffer from stress?
Yes No Do you have diabetes?
Yes No Do you experience headaches or migraines?
Yes No Sinus pressure, congestion or pain?
Yes No Do you suffer from arthritis?
Yes No Are you wearing contact lenses?
Yes No Are you wearing dentures?
Yes No Do you have high cholesterol?
Yes No Do you have high blood pressure?
Yes No Are you taking high blood pressure medication?
Yes No Do you have heart disease or family history of heart disease?
Yes No Do you have cardiac or circulatory problems? (heart attack, etc?)
Yes No Do you have Carotid Stenosis?
Yes No Thrombosis? (risk of embolism)
Yes No Do you suffer from epilepsy or seizures?
Yes No Do you suffer from joint swelling?
Yes No Do you have varicose veins?
Yes No Any Hemorrhage or Bleeding?
Yes No **Do you have contagious diseases?**
Yes No **Do you have any current infections?**
Yes No **Any fever in the past 24 hours?**
Yes No Do you have osteoporosis?
Yes No Do you experience water retention?
Yes No Any swelling or acute inflammation?
Yes No Do you have any allergies? Specific?_____
Yes No Do you bruise easily?
Yes No Any broken bones in the past 2 years?
Yes No Any injuries in the past two years?
Yes No Do you have tension or soreness in a specific area? Please specify:
_____
Yes No Do you have numbness or stabbing pains?
Yes No Are you sensitive to touch or pressure in any area?
Yes No Have you ever had surgery? List ALL major surgeries and recent minor in comments.
Yes No Splenectomy or Major Kidney Issues?
Yes No Any medical implants of any kind?
Yes No Any Auto-Immune disorders?
Yes No Other medical condition, or are you taking any medications I should know about?

**Please continue & SIGN on reverse ---->**

Yes No Do you have any active cancer, malignant ailments/tumors or any undiagnosed lumps?
Yes No Are you receiving chemotherapy?
**If YES, Please obtain your physician's approval before receiving treatment. Thank you!

**For Women ONLY:
Yes No Are you pregnant? If yes, how far along?_____
Yes No Any active gynecological infections, fibromas, cysts or IUD?_____
Yes No Are you about to begin your period or currently bleeding? Be aware that LDT may cause an increase in current menstrual flow.

Comments:_____
_____
_____
_____
_____

I understand that if I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or technique may be adjusted to my level of comfort. I further understand that manual therapy or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.
All sessions are confidential. No information will be shared with a third-party without written consent from client.

**Client Signature:**_____**Date:**_____

Practitioner Signature:_____Date:_____

Consent to Treatment of a Minor: By my signature below, I hereby authorize Laurel West, LMT to administer bodywork or manual therapy to my child or dependent as they deem necessary.

Signature of Parent or Guardian:_____Date:_____