Lymphatic Massage for Recovery
Client Intake Form

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: HOME: _____ CELL: _____

Communication Preference: Email_____ Phone_____ E-mail Address: _____

Birth Date: _____/_____/_____ Occupation: _____

In Case of Emergency, please call _____ Phone: _____

Is this injury related to a car accident? _____ Date of Accident: _____

Have you had a massage before?_____ What Kind of Massage Pressure Do You Prefer? _____

How often do you get a massage: _____Weekly _____Bi-monthly _____Monthly _____Quarterly _____Annually

Have you recently had an injury, surgery, or areas of inflammation? Where/When?_____

_____

Do you have epilepsy/seizures? _____ Do you have difficulty lying face-up or down? _____ Do you have diabetes? _____

Are you pregnant ? _____ Are you allergic to massage/essential oils? _____ Do you have osteoporosis? _____

Do you have varicose veins? _____ Where? _____

Do you have any contagious diseases or infections? _____ Where?_____

Do you have any other medical conditions or concerns that you believe we need to know about? _____ What are they?

_____

Please note any parts of your body that are experiencing pain: _____

_____

Were you referred here? _____ By whom? _____

What are your goals in receiving massage therapy?: _____

I understand that the massages I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the massage therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 physical or medical ailment of which I am aware. I understand that Diane Aurrichio, LMT is not qualified to perform spinal or skeletal adjustments, diagnose, or treat any physical or mental illness, and that nothing said in the course of this session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, or answered all questions asked of me honestly. I agree to keep the massage therapist updated as to any changes in my medical profile and understand that there shall be no liability on the massage therapists part should I fail to do so. I further understand that any illicit or sexually suggestive remarks or advances made by me to the massage therapist shall result in immediate termination of the session, and I will be completely liable for payment of the scheduled appointment. Further, I understand that Diane Aurrichio, LMT, reserves the right to refuse to administer services at her sole discretion. If at any time there are changes in the information given, or in my condition, I will notify my therapist, and update this form before receiving additional massages. I release the practitioner from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving massage. I understand that a no-show or cancellation within 24 hrs of appointment may result in a charged session. I have read and fully understand this form in its entirely.

SIGNATURE: _____ DATE: _____

CONSENT TO TREATMENT OF MINOR: By my signature below, I authorize Diane Aurrichio, LMT, to administer massage to my minor child or dependent as she deems necessary or proper.

SIGNATURE: _____ DATE _____