LymphWorks- Ft. Collins Lymph Drainage Therapy, Massage, & Energy Healing

Client Health History

Full Legal Name:_____ Date:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Daytime phone:_____ Evening phone:_____

Date of Birth:_____ Age:_____ Gender: □ M □ F Marital Status:_____

Occupation:_____ Hours per week:_____

Employer:_____ Email Address: _____

Emergency Contact:_____ Phone:_____ Relationship:_____

Referred by (so I can thank them!) or how you heard about me:_____

Chief Complaint:

Reason for visit/ **intent** for the session or series:_____

_____

_____

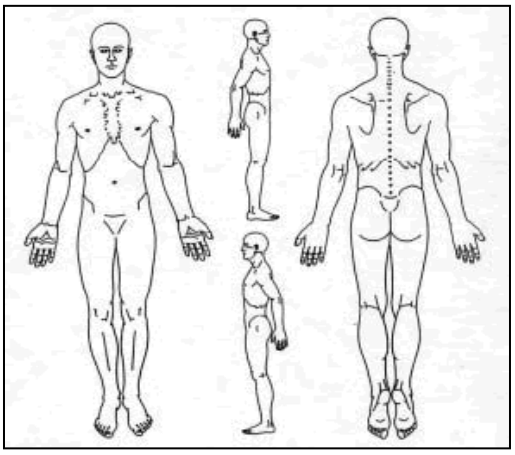
When did this condition begin?_____

Describe symptoms you have now (***mark region of pain →***):_____

_____

_____

_____



Please state diagnosis (if known):_____

What diagnostic tests (if any) have been done for this?_____

_____

What treatment(s) have you already received for this condition?_____

_____

Has any treatment helped? (if yes, please explain)_____

_____

*** Are you pregnant or have any reason to believe you may be pregnant?** **Yes** **No**

Allergies:

Are you allergic or hypersensitive to any foods, drugs, or environmental allergens? **Yes** **No**

If yes, please describe:_____

Chronic Illness:

Do you have any infectious/contagious disease? **Yes** **No**

If yes, please explain:_____

Are you currently suffering from any chronic illness? **Yes** **No**

If yes, please explain:_____

Have you or do you have any Liver, Kidney, or Heart problems? **Yes** **No**

If yes, please explain:_____

Have you ever had ***lymph nodes*** removed or ***radiation therapy***? **Yes** **No**

If yes, how many, why and where?_____

Major Medical:

Please list all hospitalizations, surgeries, significant illnesses, accidents, head injuries, or traumas you have experienced in your life:

1)_____ Date:_____

2)_____ Date:_____

3)_____ Date:_____

4)_____ Date:_____

Current Medications:

Please list all prescription medications (including hormones or birth control pills), over-the-counter medications, vitamins, herbs, or supplements you are currently taking and reason for taking them:

1)_____ reason:_____

2)_____ reason:_____

3)_____ reason:_____

Do you have any other health concerns? (please list in order of importance):

1)_____

2)_____

Regular Health Care:

Do you visit any other health practioners on a regular basis? **Yes** **No**

Doctor, Chiropractor, PT, Counselor, Acupuncturist, Naturopath, Other? Please share names:_____

_____

Other:

Particular therapy you are interested in receiving or learning more about (**please circle all that apply**)?

Lymph Drainage Therapy, Myofascial Release, CranioSacral Therapy, Healing Touch/Energy Work, Sports/NMT/Rehab, Swedish/Relaxation, Deep Tissue, Whatever the Therapist Recommends!

What are your hobbies / self care?_____

_____

Is there anything else you would like me to know about you?_____

_____

Overall, the state of your health is: **excellent** **good** **average** **fair** **poor**

How much change are you willing to make for improving your health? **minimal** **some** **complete**

Fort Collins Lymph Drainage Therapy, Massage, & Energy Healing
(970) 222-9421 **www.FortCollinsLymph-Massage.com**

I understand that:

- An assessment will be conducted to determine the general health of any one or more of the following systems: "soft tissue" (fascia, muscle, lymphatics, tendons etc), energy system, craniosacral, and/or visceral system (organs) and this information will be shared with me.
- Any suggestion made by the practitioner will be to assist my body's natural ability to achieve a balanced state to the extent that my body or my highest knowing will allow.
- The goal of my treatment will be identified as part of the treatment process and that I will have input into my goal setting.
- I understand my practitioner is a licensed massage therapist with the state of Colorado and has additional trainings and certifications in various forms of massage and bodywork therapies. Carol J. McDaniel is also a Healing Touch Certified Practitioner and Certified Reiki Master Practitioner and McKay Method Graduate.
- **These sessions are not meant to replace treatment by established medical practices but to complement them.**
- No guarantees as to the results of treatment are expressed or implied by the practitioner.
- All issues related to my session/s will be kept in confidence per the law.

I agree to:

- Raise any questions about anything I do not understand.
- Consider any suggestions that the practitioner may raise concerning referrals to other health care practitioners.
- Take full responsibility for my own health care.
- Give consent to Carol J. McDaniel, RMT or any other LymphWorks' therapist to conduct a session to balance my soft tissue (fascia, muscle, lymphatics, tendons etc), craniosacral, viscera, and/or energy system.

CANCELLATION POLICY: **If you must cancel a session, please cancel 24 hours** prior to the start time of the session. If you do not, payment is required for the missed session as other clients would be unable to schedule in the time slot I have reserved for you. (In the case of an emergency (e.g., serious illness) the fee for the late cancellation will not be waived.)

Signature_____ Date_____

Name (please print)_____ ☑ Website or brochure given to client

