First Time Client Health History Form for Advanced Therapeutic & Lymphatic Massage, LLC

3514 Trindle Rd, Camp Hill, Pa 17011 717-364-2092

Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ ❑ Male ❑ Female Physician: _____

Phone: (H)( ) _____ (C)( ) _____ (W)( ) _____

May I leave a message on voice mail that can be overheard by others? **YES** or **NO** May I text you? **YES** or **NO**

E-mail: _____ Referred by: _____

In case of emergency: _____ Phone: ( )_____

Have you ever experienced a professional massage or bodywork session? ❑ Yes ❑ No How recently?_____
What are your massage or bodywork goals?_____

What kind of pressure do you prefer? ❑ light ❑ medium ❑ firm

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from a doctor whether it is your primary care provider or oncologist, is required prior to service being provided. This will help the practitioner making sure you are provided with the best treatment plan options while keeping your doctor informed.

Please put an "X" or "√" in the correct corresponding boxes to the following questions:

Yes	No		Yes	No	
❑	❑	Do you frequently suffer from stress?	❑	❑	Do you suffer from arthritis?
❑	❑	Do you have diabetes?	❑	❑	Do you have or have had a deep vein thrombosis?
❑	❑	Do you suffer from infections?			Where?_____
❑	❑	Do you experience frequent headaches?	❑	❑	Are you wearing contact lenses or dentures?
❑	❑	Are you pregnant?	❑	❑	Are you sensitive to touch or pressure in any area?
❑	❑	Do you have high blood pressure?	❑	❑	Are you taking high blood pressure medication?
❑	❑	Do you suffer from epilepsy or seizures?	❑	❑	Do you suffer from joint swelling?
❑	❑	Do you have varicose veins?	❑	❑	Do you have osteoporosis?
❑	❑	Do you have any contagious diseases?	❑	❑	Do you have any allergies?
❑	❑	Are you sensitive to smells?	❑	❑	Have you had any lymph node removal?
❑	❑	Do you have cardiac or circulatory problems?	❑	❑	Do you suffer from back pain?
❑	❑	Do you bruise easily?	❑	❑	Are you feeling well today?
❑	❑	Do you have numbness or stabbing pains?	❑	❑	Have you had Covid-19**?**
			❑	❑	If yes to covid-19, do you have a clotting issue?

❑ ❑ Have you ever had surgery, broken bones, or injuries in the past two years?
Explain:_____
_____

❑ ❑ Have you had or currently have cancer?
(If you answered **YES**, please have physician fill out and sign the *Physician Permission form* (found in client form tab on web page or sent to you via email) and have it with you at time of your appointment. If you do not have the Physician Permission form signed or with you at time of your appointment, we will have to reschedule your appointment until you do obtain this signed form from your physician.)
What type of cancer? _____
Are you currently under treatment? YES or NO
Is your Doctor aware of you getting a massage? YES or NO

Please see back of form

Other medical condition and or are you taking any medications I should know about?

Comments: _____

Do you have a specific area of tension or soreness that you want the therapist to address today?

Please specify: _____

By signing below, I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension and discomfort. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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. Also, if for any reason I am LATE or am a NO SHOW for my treatment, I will be charged for the entire session or will not be rescheduled until payment is made.

Client Signature: _____ Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize April Evanitsky to administer massage, bodywork, or somatic therapy techniques to my child or dependent, as they deem necessary.
Signature of Parent or Guardian _____ Date _____

Therapist reviewed with the above named lymphatic indications, contraindications and effects that lymphatic drainage/lymphatic massage may have on his or her body.

Therapist Signature: _____ Date: _____
Client initials_____

I, _____, give this therapist, April Evanitsky, permission to touch breasts to address issues that need to be address through lymphatic massage and scar release.

Client Signature: _____ Date: _____
Therapist initials_____