BACK TO HEALTH

Massage & Manual Lymph Drainage Clinic

REGISTERED · MASSAGE · THERAPIST RMT

MANUAL LYMPH DRAINAGE THERAPY - CONFIDENTIAL PATIENT HISTORY FORM

Name _____

Address _____

_____

Postal Code _____

Phone (home) _____

(cell/pager) _____

(work) _____

Email _____

Occupation _____

Birthdate _____
(month / day / year)

Family Doctor _____

Phone _____

Referring Professional _____

Phone _____

OFFICE USE

Care Card # _____

How did you hear about our clinic?_____

Please indicate if you believe if any of the following apply to you? (P = past C = current)Circle if necessary.

_Heart Attack
_High / Low Blood Pressure
_Stroke or Aneurysm
_Pace Maker
_ other Heart condition
_Varicose Veins
_Bruise easily
_other Circulatory condition

_Diabetes
_Kidney Disease
_other Urinary condition

_Auto-immune disorder

_Headaches / Migraines
_ Dizziness / Fainting
_ Nausea
_ Spinal Injury
_ Head Injury
_ Epilepsy / other seizures
_ other Neurological condition

_ Asthma
_ Chronic Sinusitis
_other Respiratory condition

_ Irritable Bowel / Colitis
_ Digestive condition
_ Skin condition

_ Joint Dislocation
_ Bone Fracture
_ Arthritis
_ Osteoporosis
_ Rods / Pins / Plates / Shunts
_ Implants _____
_ Transplant _____
_ Corrective Lenses/Contacts

_ Cancer
_Hepatitis
_ HIV
_ other Contagious condition

List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

_____

_____

Smoker Yes No Occasional
Alcohol Yes No Occasional

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of Sleep 1 2 3 4 5 Hrs per night _____
Energy Level 1 2 3 4 5
Eating Habits 1 2 3 4 5 Meals per day_____
Stress Level 1 2 3 4 5
Exercise Habits 1 2 3 4 5 Times per wk _____

Please list any Medications/Vitamins/Minerals/Supplementsyou presently taking:

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

Patient History Form cont…

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Current Condition

What is your condition?_____

Do you know the cause of the lymphedema/Swelling?

Cancer _____

Diabetes_____

Accident _____

Surgery_____

Infection_____

Ulcers_____

Fibromyalgia/MS/ChronicFatigue etc_____

Other_____

How long have you had: the diagnosis _____, when did the lymphedema start? _____

Did is appear sudden or gradual? _____. What type of treatment did you receive(indicate dates)_____

What type of treatments have you received for your lymphedema?_____

Do you have compression Garments?_____ How often do you wear it _____

Please describe your symptoms for on a scale of 1 (non- existent) to 10 (most severe)

Pain: Mobility: Bursting: Increased temperature: Numbness: Loss of sensation:

Have you ever had an infection/cellulitis in the limb?(dates)_____

Was it treated with antibiotics?_____ Which type?_____

Have you recently noticed any changes in the skin_____nails_____

Are any areas of the limb noticeably harder than usual?_____

At home : do you have someone to help you with day to day functions:_____name_____

If you have an arm lymphedema, treatment of full body detox we will need to work on the chest area: Yes/No ____

If you have a leg lymphedema, we will need to work on the upper medial thigh and buttock area. Are you willing to consent to the treatment of these areas? Yes/No _____

For all lymphedemas that are the result of cancer surgery, you must bring a medical referral indicating your condition, the stage of the cancer and if chemotherapy and/or radiation was a part of the treatment plan.

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient. _____

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: _____ **Date:**_____