

# Client Intake Form for Lymphatic Massage



**BEE LUXE**  
MED SPA

## General Information

Name  Date of Birth

Address

City  State  Zip Code

Phone #  Email

Occupation

Physician's Name  Physician's Phone #:

Emergency Contact Name  Phone #

Would you like to be added to our email list for specials and discounts? Yes  No

How did you hear about us?

## Medical History

Please check all that apply: Temp: \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Bursitis             | <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Chronic Cough        | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Digestive Conditions |
| <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Fibromyalgia         |
| <input type="checkbox"/> Frequent Colds       | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Hearing Loss         |
| <input type="checkbox"/> Heart Attacks        | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Hemophilia           |
| <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Herpes              | <input type="checkbox"/> HIV/AIDS             |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Jaw Pain (TMJ)      | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Lyme Disease         | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Numbness/Tingling    |
| <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Poor Circulation     |
| <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Rashes              | <input type="checkbox"/> Ringing In Ears      |
| <input type="checkbox"/> Sciatica             | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Sensory Loss/Change  |
| <input type="checkbox"/> Shortness of Breath  | <input type="checkbox"/> Sinusitis           | <input type="checkbox"/> Smoker               |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Tendonitis          | <input type="checkbox"/> Vertigo/Dizziness    |
| <input type="checkbox"/> Vision Loss          | <input type="checkbox"/> Vision Problems     | <input type="checkbox"/> Other: _____         |

Are you currently under medical care? Yes  No

Are you or could you be pregnant? Yes  No

Are you currently taking any medications? Yes  No

If yes, please explain:

Do you have any allergies? Yes  No

If yes, please explain:

Do you see a chiropractor? Yes  No

If yes, how often:

Do you suffer from chronic pain? Yes  No

If yes, please explain:

Do you sit for long periods of time? Yes  No

If yes, please explain:

Have you had any major accidents or surgeries? Yes  No

If yes, date, please explain:

### Additional Information

Have you had a professional massage before? Yes  No

If yes, when and how often:

Do you have difficulty laying on your front, back, or side? Yes  No

If yes, please explain:

Are you sensitive to touch or pressure on any areas of your body? Yes  No

If yes, where:

Are there areas that you do not want massaged? Yes  No

If yes, where:

How would you describe your stress level (1 being lowest, 10 being highest):

1  2  3  4  5  6  7  8  9  10

Are you sensitive to fragrances or perfumes? Yes  No

Do you have sensitive skin? Yes  No

Do you wear contact lenses? Yes  No

Do you wear dentures? Yes  No

Do you wear a hearing aid? Yes  No

Do you exercise regularly? Yes  No

Do you perform repetitive movements while you work, exercise, or for recreation? Yes  No

What are your goals for this massage session?

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the massage therapist of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the massage therapist of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my massage therapist and the spa, Bee Luxe Med Spa for any injury or damages incurred due to any misrepresentation of my health.

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Lymphatic Massage Informed Consent Form



Please take a moment to read and initial the following information:

\_\_\_\_\_ I understand the benefits and risks of manual lymphatic drainage massage and give my consent for massage.

\_\_\_\_\_ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.

\_\_\_\_\_ I understand that there is no implied or stated guarantee of the success of the effectiveness of individual techniques or series of appointments.

\_\_\_\_\_ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

\_\_\_\_\_ I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

\_\_\_\_\_ I affirm that I have notified my therapist of all known medical conditions and injuries.

\_\_\_\_\_ I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

\_\_\_\_\_ I understand that massage is entirely therapeutic and non-sexual in nature.

\_\_\_\_\_ I understand that draping will be used for my privacy and that genitalia and women's breasts will not be exposed or touch at any time.

\_\_\_\_\_ I 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.

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Massage Therapist Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date