

Patient Intake Form "LYMPHATIC THERAPY"

Date: _____

Name: _____ Date of birth _____

Phone Numbers: (C) _____ (W) _____

(H) _____ Email _____

Address: _____

City: _____ State _____ Zip code: _____

Emergency Contact: _____ Phone: _____

Occupation: _____

How did you hear about Myo Pain Center OC? _____

Your: Height _____ Weight _____ Right handed Left handed

Do you have children? Yes / No How many? 1 2 3 4 5 Age(s) _____

Check One: Married Divorced widowed single separated partner

Have you received Lymphatic Therapy before? Yes No

Have you ever been treated for cancer?

a. Surgery? Yes / No

b. Radiation? Yes / No

Chemotherapy? Yes / No

Did your treatment include the removal, radiation, or testing of lymph nodes? Yes / No (circle)

Have you ever been diagnosed with a blood clot?

Reason for seeking Lymphatic Therapy?

Please circle any items you are currently wearing:

Pacemaker Hearing Aid contact lenses electronic devices such as an insulin pump

Others: _____

Are you aware of having (or have you been diagnosed as having) any of the following conditions? Please check which ones and indicate "P" for past and "C" for current.

- 1. Asthma Allergies Bronchitis Emphysema Hepatitis
- 2. Angina Diabetes Stroke High blood pressure Low blood pressure
- Congestive heart disease varicose veins Thrombosis blood clots bursitis
- Arthritis Skin infection Osteoporosis High PSA Pregnant Food allergies

3. Chronic constipation hemorrhoids Severe diarrhea Alcoholism Addiction
 Thyroid disorders Candidacies Irritable bowel Depression Cancer
 Endometriosis eating disorders

Do you have implants of any kind, including breast implants or metal joint of other replacements? YES NO

If so, where? _____

Check One: Surgeries with date: _____

Hospitalization with date: _____

Injuries / accidents with date: _____

Prescription drugs: (include dosage) _____

Supplements: _____

I smoke ___ cigarettes cigars pipes per day. I don't smoke.

drink ___ cups of coffee tea caffeinated soda per day

drink ___ alcoholic beverages?per day.

How much water do you drink per day?

How to prepare

It is important to plan for your session. Please adhere to the following to achieve the best results:

- Come in for your session with dry skin – refrain from showering or bathing at least 3-4 hours prior to your session.
- Do not wear any lotion, oils, deodorant, perfume, or makeup (if you want us to include your face).
- You might consider leaving your jewelry at home, as we will need you to remove all metal prior to the session.

I have completed this health form to the best of my knowledge. I understand that the Myo Pain Center OC (MPCOC) and the Lymphatic Manual technique services are a therapeutic health aid and do not take the place of a physician's care when indicated. The MPCOC is not involved on the diagnosis or cure of any disease whatsoever. The therapeutic methods being used by MPCOC are used only in the context of rehabilitation or for the beautification of the body.

CONTRA INDICATION FOR THE BODY WHICH WILL RESULT IN NO TREATMENT IF YOU HAVE:

1. CONGESTIVE HEART CONDITION 2. Thrombosis (blood clots) 3. Pacemaker
4. Active Malignancy 5. Acute infectious disease

By signing this release, I hereby waive and release MPCOC / Carlos Messerschmidt from any and all liability, past, present, and future relating to bodywork received at

I understand that MPCOC, and any of the methods they represent, are not being used for diagnosis, treatment or cure of disease.

Signature

Date
