AUSTIN
LYMPHATIC

If this is your first visit with us, fill out this Client Intake Form, print it, and bring it to your appointment **OR** arrive 10 minutes early to fill it out in the office.

Date: _____
Phone: _____
Email: _____
Emergency Contact Name + Phone: _____
Name: _____ Date of Birth: _____
Address : _____
_____

How did you hear about Austin Lymphatic/Referral Source: _____
_____
Reason for coming in today/goals: _____
_____
Please list any medications you are currently on: _____

Do you have an IUD? Yes / No
Are you sensitive/allergic to any lotions, oils, essential oils, or nuts? If so, please list: _____
_____

Do you have any open wounds or contagious skin infections? Yes / No
Do you have an autoimmune condition? If so, please explain: _____
_____

Have you **EVER** had **ANY** lymph nodes removed or radiated? Yes / No How many? _____
What part of the body? _____

If you are here due to a recent surgery/procedure:

Date of Surgery: _____ Surgeon's Name: _____
Practice Name: _____ Phone: _____
What kind of surgery? _____
Areas of concern/problems: _____
_____

Are you under any physical restrictions from your doctor, e.g. lying flat, exercise?
Please explain: _____
_____

If you are currently being or have ever been treated for cancer:

What kind? _____ What stage? _____
Oncologist's name: _____ Chemo: _____
Number of rounds: _____
Last treatment date: _____
Radiation: _____
Number of rounds: _____
Last treatment date: _____

Have you had lymph nodes removed? Yes / No
If yes, how many and from where? _____

Do you have lymphedema? Yes / No
(If yes) What stage? _____
(If yes) Where is it and how long have you had it? _____
_____

We approach your concerns using integrative lymphatic therapy, which offers various modalities. These include Manual Lymphatic Drainage, Kinesio-taping, Massage Cupping, Scar Tissue Work, Friction, Physical Therapy, Occupational Therapy, Reflexology, Zero Balancing, Swedish Massage, and Ashiatsu. During a session, we may use a combination of these techniques to achieve the best result.

If you currently have any of the following conditions, we will be unable to offer a lymphatic session until you've seen a medical doctor and are cleared to receive lymphatic drainage. Please note this for future appointments:

___ Absence of Urination	___ Acute Infection	___ Cardiac Blockage
___ Clots	___ Congestive Heart Failure	___ Deep Vein Thrombosis
___ Fever	___ First Trimester of Pregnancy	

The following conditions may indicate that we possibly need to adjust your session. Depending on your symptoms, we may use gentler pressure. For other conditions, we may use deeper pressure, or avoid the area altogether if indicated. This helps us to dial in the session for your specific need. Please indicate if the following apply:

___ Asthma	___ Cardiac Arrythmia	___ Crohns Disease
___ Currently Menstruating	___ Flair-up	___ Hepatitis
___ Hyper/Hypothyroidism	___ IBS	___ Phlebitis
___ Pregnant	___ Recent Injections	___ Undiagnosed Lump
___ Unexplained Pain	___ Recent Botox/Filler	

Below is a basic list of things lymphatic drainage can help with. Please indicate if any of the following apply so we can focus on these areas:

___ Allergies	___ Arthritis	___ Venous Insufficiency
___ Autoimmune Condition	___ Burns	___ Chronic Pain
___ Fibromyalgia	___ Cellulite	___ Chronic Fatigue
___ Neck/Back Pain/Whiplash	___ Constipation	___ Diabetes
___ Toxic Chemical Poisoning	___ Headaches	___ Lymphedema
___ Water Retention	___ Painful Menstruation	___ Scar Tissue

Please list any other ailment you would like for us to address: _____
_____
_____

AUSTIN LYMPHATIC

Office Policies and Consent for Treatment

Austin Lymphatic has a strict 24-hour cancelation policy. Your card will be charged 1/2 the price of the appointment if you cancel without 24 hours' notice. No-show appointments will be charged the full rate and future appointments may be canceled if you fail to follow up with our communication.

Please initial to indicate your understanding:

_____ I understand Austin Lymphatic's Cancelation Policy and that my card will be charged in the event I don't offer 24 hours' notice or don't show up for an appointment. No exceptions.

_____ If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure may be adjusted to my level of comfort.

_____ I understand that if I've had lymph nodes removed or radiated, I have an inherent risk of developing lymphedema at any time and don't hold Austin Lymphatic responsible for the development of lymphedema.

_____ I understand that massage/bodywork should not be 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 Austin Lymphatic 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 or over email/text should be construed as such.

_____ I understand that the genital area and glutes will be covered at all times during my session.

_____ I understand that if I am uncomfortable for any reason, I may ask the practitioner to stop the massage and the massage session will be ended.

_____ I understand that if I initiate any verbal or physical contact that is sexual in nature, the practitioner will immediately end the massage session.

_____ I understand that the name, mailing address, phone number, and web address at which I may direct complaints to their board is listed on the wall.

Client's Printed Name: _____
Client's Signature: _____

Practitioner's Printed Name: _____
Practitioner's Signature: _____ Date: _____

AUSTIN LYMPHATIC

Breast Massage Consent Form

(Not Required Unless Receiving Breast Massage)

Please initial the statements below. Please ask your therapist any questions you have regarding treatments or let them know if you are unclear in any way regarding the requested consent.

Consent for Breast/Chest Massage: It is my choice to receive a breast massage. I understand that the treatment being given is for the purpose of improving breast health. These techniques are designed to reduce tenderness, pain, swelling, and to enhance circulation and lymphatic flow from the breast tissue and to promote healthy tissue before and after surgery.
____ I consent to receive a breast massage.

Massage of tissue AROUND or underneath breast/chest tissue: In order to achieve treatment goals, your therapist might deem it appropriate to work on muscle or connective tissue near or underneath breast/chest tissue (for example, pectoralis or intercostal muscles). Your therapist will do their best to avoid breast tissue and minimize pressure. Please let them know any time treatment feels uncomfortable in any way.
____ I consent to my chest (not actual breast tissue) being touched during the massage treatment for the purpose of working with surrounding or deeper structures.

Consent for Draping: State law requires that draping be provided during a massage and ensures that the following areas will not be exposed during a massage: breast/chest, genitals, and gluteal cleft. There are several exceptions:

- Temporary removal of draping can occur for the gluteal cleft area and breasts with written, verbal, and signed informed consent.
- Breast draping may be removed for the duration of the session with written, verbal, and signed informed consent.

____ Breast/chest: I consent to my breast being uncovered during breast massage.
____ Assistance with dressing/undressing: I require assistance with dressing and undressing, which may expose my breasts and gluteal cleft area. I consent to this assistance.

I understand that I have the right to rescind my consent and refuse any of the above treatments at any time, even in the middle of a treatment session. The consent is valid until I inform my therapist that I want to change it.

Client's Printed Name: _____
Client's Signature: _____

Practitioner's Printed Name: _____
Practitioner's Signature: _____ Date: _____