THE PIPER CENTER
For Internal Wellness

THE PIPER CENTER *for Internal Wellness*
Lymphatic Massage Intake Form

Please help us provide you with the most effective service by completing the following questions. All information is kept ***confidential.***

Personal Data: (please print)

First Name _____ Last Name _____

Address _____ City/State/Zip _____ _____ _____

Phone Home _____ Work Cell _____ email _____

Occupation _____ Date of Birth _____ Gender _____

Emergency Contact _____ Phone _____

Reason for seeking Lymphatic Enhancement Therapy:

_____

Please check any items you are currently wearing:

☐ Contact Lens ☐ Pacemaker ☐ Hearing Aid ☐ Hairpiece Other _____

Medical History (please check all that apply)

Skin Conditions:

☐ Boils ☐ Fungal Infections (athlete's foot, ringworm etc) ☐ Herpes ☐ Warts ☐ Warts

☐ Eczema ☐ Hives ☐ Moles ☐ Psoriasis ☐ Skin Cancer ☐ Allergies _____

Respiratory System Conditions:

☐ Bronchitis ☐ Cold ☐ Influenza ☐ Pneumonia ☐ Sinusitis ☐ Tuberculosis ☐ Asthma

☐ Emphysema ☐ Lung Cancer ☐ Chronic Cough ☐ Allergies _____

Endocrine System Conditions:

☐ Diabetes ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Hypogylcemia

Musculoskeletal Conditions:

☐ Fibromyalgia ☐ Sprains/Strains ☐ Osteoporosis ☐ Gout ☐ Carpal Tunnel ☐ Lyme Diseas

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Whiplash ☐ Herniated Disc

Reproductive System Conditions:

☐ Cervical Cancer ☐ Endometriosis ☐ Fibroid Tumors ☐ Breast Cancer ☐ Ovarian Cancer

☐ Prostate Cancer ☐ Pelvic Inflammatory Disease ☐ Pregnancy ☐ PMS

Nervous System Conditions:

☐ Multiple Sclerosis ☐ Parkinson's ☐ Bell's Palsy ☐ Spinal Cord Injury ☐ Stroke ☐ Seizures

☐ Headaches ☐ Migraine ☐ Tension ☐ Cluster ☐ PMS ☐ Stress ☐ Sleep Disorders ☐ Anxiety ☐ Chemical Dependency ☐ Depression

Digestive System Conditions:

☐ Indigestion ☐ Constipation/Diarrhea ☐ Reflux Disorder ☐ Stomach Cancer ☐ Ulcers
☐ Appendicitis ☐ Colorectal Cancer ☐ IBS ☐ Ulcerative Colitis ☐ Hepatitis ☐ Gallstones
☐ Allergies _____

Circulatory System Conditions:

☐ Anemia ☐ Blood Clot ☐ Hematoma ☐ Leukemia ☐ Clotting/bleeding problems
☐ Atherosclerosis ☐ Hypertension (HBP) ☐ Low Blood Pressure ☐ Varicose Veins ☐ Heart Disease
☐ Heart Attack ☐ Heart Failure

Lymph & Immune System Conditions:

☐ Oedema ☐ Lymphoedema ☐ Chronic Fatigue Syndrome ☐ Fever ☐ HIV/AIDS ☐ Lupus
☐ Epstein Barr (Glandular Fever)

Urinary System Conditions:

☐ Kidney Stones ☐ Urinary Tract Infection (UTI) ☐ Bladder Cancer

Current Medications: (prescription and natural)

Medication Name	Prescribed By	Dosage

Any further information relevant:

_____

_____

_____

_____

_____

I have read and agree to the polices of THE PIPER CENTER *for Internal Wellness*

- Please be on time. If you are late, a shortened session will be charged at the full rate.
- We request payment in full at the time of your visit. We accept cash, Visa, MasterCard and personal checks.
- A referral from your primary health care provider or our supervising physician is required if you a condition or are following a prescribed treatment.
- We require 24 hours notice for all cancellations or postponements: otherwise you will be charged the full session. As a courtesy, we give clients a telephone reminder a day or two before an appointment.
- All series must be used within 1 year. No refunds are given after the 1 year expiration date.
-

I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder. The therapist does not prescribe medical treatment or pharmaceuticals. It has been explained to me that colon therapy is not a cure or substitute for a medical examination, treatment or diagnosis. It is recommended that I see physician for any ailments that I might have. All information that I provided is correct to the best of my knowledge. If any health issues arise, I agree to inform my therapist.

I understand that Lymphatic Enhancement Therapy is for improving lymphatic flow and circulation. I have stated all of my known medical information and understand that it is my responsibility to keep my lymphatic enhancement practitioner informed in any changes in my health and of any medications I may take in the future. I also understand that lymphatic enhancement therapy is not a substitute for medical treatment and that I should see a doctor/health care provider for diagnosis and treatment for any suspected medical problem.

Thank you for choosing THE PIPER CENTER *for Internal Wellness* for your alternative medical care. We look forward to working with you in your journey toward Health Inside and Out.

Signature: _____ Date: _____

Date:

LP Frequency: _____ Anatomy Covered: Lymphatic Trunk, Breast, Cisterna Chyli, Illiac Nodes, Popliteal Nodes, Axillary Nodes, Parasternal, Abdomen/Colon, Inguinal Nodes, Back

NOTES:

Date:

LP Frequency: _____ Anatomy Covered: Lymphatic Trunk, Breast, Cisterna Chyli, Illiac Nodes, Popliteal Nodes, Axillary Nodes, Parasternal, Abdomen/Colon, Inguinal Nodes, Back

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Date:

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NOTES:
