NEW PATIENT INTAKE FORM

** Confidential **

John Mulligan, RMT/CLT-LANA
Lymphedema Therapy, Education and Consulting
12-111 Fourth Ave., Suite 347, St. Catharines, ON L2S 3P5
T: (905) 687-1828 E: John@LymphedemaTherapist.com

PERSONAL INFORMATION

Name: _____ Date: _____

Street Address: _____ City: _____ Province: _____

Postal Code: _____ Telephone (day): _____ (evening): _____

Email Address: _____

Emergency Contact: _____

Weight: _____ Height: _____ Age: _____ Date of Birth: _____ Sex: _____

Occupation: _____ Hours worked per week: _____

Recreational Activities: _____ Frequency: _____

How did you hear about my clinic?: _____

Reason for seeking this treatment: _____

HEALTH HISTORY

Please indicate the conditions that apply ✓

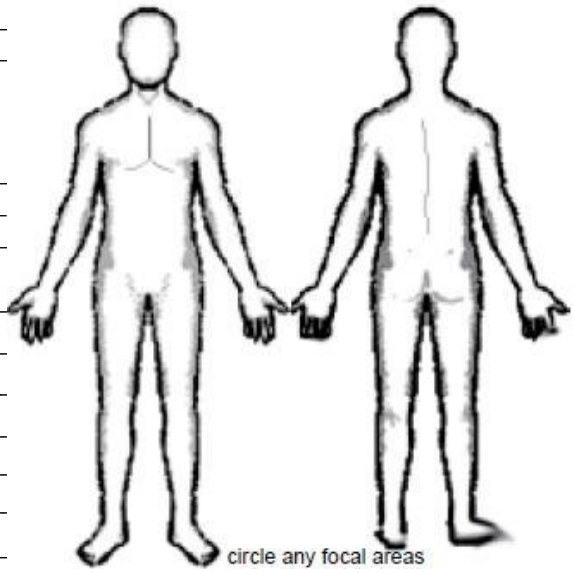
_____Headaches (migraine)
_____Headaches (sinus)
_____Headaches (tension)
_____Sinus infections (frequent)
_____Allergies
_____Frequent colds
_____Pregnant currently
_____Shortness of breath
_____Chronic chest congestion
_____Chronic cough
_____Are you a smoker?
_____Packs per day

_____Night pain
_____Sleep disturbed by pain
_____Rheumatoid Arthritis
_____Osteoarthritis
_____Back pain
_____Neck pain
_____Shoulder pain
_____Chronic constipation
_____Difficult digestion
_____Diabetes
_____Frequent urination
_____Night sweats

_____High blood pressure
_____Low blood pressure
_____Dizziness
_____Diagnosed heart disease
_____Varicose veins
_____Poor circulation
_____Phlebitis
_____Sensitive skin
_____Rashes (frequent)
_____Skin eruptions (frequent)
_____Bruise easily
_____Swollen ankles

Lymphedema_____ Lipedema_____ Chronic Venous Insufficiency _____

Lymphedema diagnosis? Y ❑ N ❑ Onset/How long? _____
Lymphedema since childhood? Y ❑ N ❑ Family history? _____
Swelling goes down at night? Y ❑ N ❑
Lymphedema-related pain ? Y ❑ N ❑
Related infection(s)? Y ❑ N ❑
Lymphedema due to cancer? Y ❑ N ❑ Diagnosis date: _____
If yes, lymph nodes removed? Y ❑ N ❑ How many? _____
Radiation treatment received? Y ❑ N ❑ _____



Present status of cancer: _____
Oncologist and date of last visit: _____
Explanations, as needed: _____
_____
_____
_____

Do you wear a compression garment? Y ❑ N ❑ _____

Please turn over and complete opposite side of form

NEW PATIENT INTAKE FORM

** Confidential **

John Mulligan, RMT/CLT-LANA
Lymphedema Therapy, Education and Consulting
12-111 Fourth Ave., Suite 347, St. Catharines, ON L2S 3P5
T: (905) 687-1828 E: John@LymphedemaTherapist.com

Any other doctor diagnosed conditions? Please specify:

Recent surgeries (within the last ten years) including date(s):

Current medications:

Your referring / primary care physician:

Name: _____ Telephone: _____

Address: _____

Other health care ✓

Chiropractic _____ Physiotherapy _____ Naturopathic _____ Acupuncture _____ Osteopath _____

Other (specify) _____

Have you had previous massage therapy experience? Y ❑ N ❑ Manual Lymph Drainage in the past? Y ❑ N ❑

PLEASE READ CAREFULLY AND SIGN BELOW

All statements made on this form are true to the best of my knowledge. I understand that all personal information provided is confidential as governed by law except to facilitate treatment or diagnosis. All information given here is given only to assist the therapist in delivering appropriate, safe and beneficial massage therapy treatments. All treatments will be within the scope of practice of massage therapy as defined by the Massage Therapy Act of 1991.

I understand that the nature and purpose of the treatment will be explained to me and that I have the right to stop or modify the treatment at any time, as does my Registered Massage Therapist. I understand I have the right to ask questions at any time. I understand that the benefits of massage therapy include increased circulation to the tissues and increased relaxation, among other effects, and that I may feel temporary soreness post-treatment (24-48 hours) or a slight dizziness on rising from the table. I understand that my therapist must obtain consent to treat areas of my body that I have not previously given verbal consent to have treated. I do consent to treatment; I also understand that verbal consent must be given before any treatment.

I understand that I am responsible for payment in full of all treatment and related fees immediately following each of my appointments by cash, cheque, Visa or MasterCard. I understand that 24-hours notice by telephone is required to re-schedule any future appointment, or full charges will apply.

_____ _____

Client signature Date