Massage by Julia Julia Morrow, CMT/CMLDT/CLT 818.421.0597

Massage/Lymphatic Drainage Therapy Client Health/Consent Form

Name: _____
Address:_____
Home Phone: _____ Cell Phone: _____
Occupation: _____ Email:_____
How did you hear about *Massage by Julia*? _____

Yes√	***No√***	
___	___	Have you had a professional massage before? Most recent date?
___	___	Have you ever had Manual Lymphatic Drainage Therapy (MLD) before?
___	___	Do you exercise several times per week? Type?
___	___	Do you stretch several times per week? # of mins?
___	___	Have you had cancer? If yes, please fill out the back.
___	___	Do you have Lymphedema or Lipedema? If yes, please fill out the back.
___	___	Are you currently taking any medications? For what conditions?
___	___	Are you allergic to shellfish?

Circle if you have:

Frequent headaches	Liver/kidney problems	Arthritis
High BP/Congestive Heart Failure	Stroke/Clots/phlebitis/DVT	Scars that cause pain/pulling
Numbness/tingling/stabbing pain/neuropathy	Surgery on abdomen/shoulder/knee/hip/back?	Scoliosis/Osteoporosis/Osteopenia
Tension in a specific area? Where?	Diabetes	Fibromyalgia

Please use this space to expand any answers from above & also write your main issue for today's session:

_____
_____
_____
_____

I understand that:

- Massage is for the basic purpose of relaxation, mental stress, relief of muscular tension, & pain relief.
- MLD assists with moving lymph, speeds healing, reduces bruising/scarring/pain/swelling, and boosts immunity.
- If I experience any pain or discomfort during this session, I will immediately inform the practitioner.
- Massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, & that nothing said in the course of the session(s) should be construed as such.
- I have stated all my known medical conditions & answered all questions honestly.
- The practitioner will keep my health information **confidential**, & she has my consent to consult with my physician.
- Also, 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.

No Show Policy: Clients must pay for their missed appointment, & are welcome to reschedule as soon as they have paid for the missed appointment.

Late Arrivals: Clients will be given a massage for the remaining minutes of their appt.

Sign: _____ Date: _____

Cancer survivors, please fill out this section:

Type of cancer and location _____
Date(s) of diagnosis _____
Are you experiencing any pain? If yes, where? _____
Are you on medications for inflammation or pain? _____
Do you have fragile bones: Yes No Don't Know
How is your general energy level? _____
Have you had lymph nodes removed? Yes No Don't Know
If yes, from where? _____
Number of nodes removed _____

Have you had:	Yes	No	Ongoing	Completion Date
Cancer-related surgery*				
Reconstruction				
Chemotherapy				
Radiation				
*List surgeries here:				

During your massage session, are you able to lie on your stomach/back/side?

Please circle if you currently have:

Nausea	low appetite	fatigue	bruising
neuropathy	edema	rash	bone pain
scars/adhesions	joint pain	dry/fragile skin	blood clots
catheter	port	expanders	PICC line

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If you have Lymphedema or Lipedema:

Where is your lymphedema? _____
Do you wear compression garments? _____
Lipedema surgeon's name & date(s) of surgery: _____

Have you had:	Yes	No	If yes, have you been cleared by your physician?
Congestive Heart Failure			
Cellulitis			
Deep Vein Thrombosis			
Chronic Inflammatory Bowel Disease/Crohn's Disease/Ulcerative Colitis			