LifeSource Lymph and Wellness
, 1755 Orange Avenue
Suite B
Costa Mesa, CA 92627
714-287-9929
www.lifesourcelymph.com
hlinghands@aol.com

Client Information Form

Name: _____

Address: _____

State: _____ Zip: _____ Email: _____

Telephone: Wk _____ Home _____ Cell _____

Date of Birth: _____ Occupation: _____

Referred By: _____

Emergency Contact: _____ Phone: _____

Reason for seeking Lymphatic Therapy:

_____

_____

_____

_____

Please circle any items you are currently wearing:

Contact Lenses Pacemaker Hearing Aid Hairpiece

Other: _____

Consent for Care:
I understand that Lymphatic Enhancement Therapy Solutions 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 of 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.

Signature: _____ Date: _____

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Name: _____ Age: _____

Present Health Concerns (in order of importance): **Durantion:**

1. _____ _____
2. _____ _____

Medical/Health History:

Current Health Provider(s): Phone: Reason for Seeing:

_____ _____ _____

_____ _____ _____

Date of last full examination: _____ Results: Normal Abnormal
Date of last labwork & urine test: _____ Results: Normal Abnormal
Date of last prostate exam: _____ Results: Normal Abnormal
Date of last PAP and pelvic exam: _____ Results: Normal Abnormal
Date of last Mammogram: _____ Results: Normal Abnormal
Date of last DEXA or bone imaging: _____ Results: Normal Abnormal

Surgeries with dates: _____

_____

Hospializations with dates: _____

_____

Illnesses with dates: _____

_____

Injuries with dates: _____

Allergies: (drugs, food, environmental) Please circle if any are life threatening: _____

_____

Prescription drugs (include dosage): _____

_____

Suppliments: _____

_____

Previous Holistic treatments: _____

Medical/Family History:

Condition	Self/Family Member	Condition	Self/Family Member
Allergies		Kidney Disease	
Alcoholism		Mental Disorder	
Anemia		Obesity	
Rheumatoid Arthritis		Stroke	
Osteo Arthritis		Thyroid (high/low)	
Diabetes		Osteoporosis	
Cancer		Fractures (mom/grandma)	
High Cholesterol		Autoimmune Disease	
Epilepsy		Bleeding tendency	
Heart disease		High blood pressure	

Social History

Personal Habits (Please list current, or past use, frequency and quantity):

Tobacco: _____ Caffeine: _____ Alcohol: _____ Recreational Drugs: _____

Exercise: List type of activities and frequency: _____

_____

Diet History (include any liquids):

Breakfast yesterday: _____ AM snack: _____

Lunch yesterday: _____ PM snack: _____

Dinner yesterday: _____ Late PM snack: _____

Bars/Shakes: _____ Glasses of plain water: _____

Please list any dietary restrictions: _____

What level of change to your living habits are you willing to make to improve your over-all well-being?

Whatever it takes Significant change Some change No change

Review of symptoms (check if you now have or circle if you previously have had):

Hematologic:
- Anemia
- Blood diseases
- Fatigue
- Dizziness
- Excessive bleeding
- Abnormal bruising
- Blood clots

Skin/Nails:
- Skin rash/hives
- Brittle nails

HEENT:
- Headaches
- Hearing loss
- Ringing in the ears
- Vision loss/changes
- Eye pain/itchy eyes
- Sore throat
- Sneezing/runny nose
- Nosebleeds
- Sinusitis
- Jaw pain
- Mouth/tongue sores

Systemic Review:
- Hot flashes
- Night sweats
- Excessive sweats
- Fever
- Chills

Gastrointestinal:
- Bad breath
- Ulcers
- Constipation
- Heartburn
- Stomach ulcers
- Diarrhea
- Nausea
- Vomiting
- Rectal itching
- Hemorrhoids
- Hepatitis/Jaundice
- Bitter taste in mouth
- Burping
- Gas
- Cramping
- Bloating
- Laxative use
- Blood in stool
- BM frequency_____
- Color of stool_____

Musculoskeletal:
- Difficulty walking
- Muscular pain
- Joint pain/stiffness
- Muscular weakness

Endocrine:
- Hair loss/thinning
- Dry skin
- Hormone therapy

Cardiovascular:
- Stroke
- Nosebleeds
- Varicose veins
- High/low blood pressure
- Chest pain
- Heart disease
- Irregular heart beat
- Swelling/Edema
- Cold hands/feet
- Varicose veins

Nero-psychiatric:
- Tingling
- Weakness
- Numbness
- Seizures
- Paralysis
- Poor balance
- Poor memory
- Poor concentration
- Depression
- Anxiety
- Eating disorder

Respiratory:
- Tuberculosis
- Asthma/weezing
- Difficulty breathing
- Cough
- Pneumonia
- Other_____

Genitourinary:
- Kidney infection
- UTI
- Kidney disease
- Blood in urine
- Frequent urination
- Night urination
- Incontinence
- Testicular issues
- Prostate problems
- Sexual disfunction
- STD_____

Gynocological:
- Menopause
- Breast lump
- Breast discharge
- PMS
- Period started_____
- LMP_____
- Period last____days
- Pain with period
- Heavy bleeding
- Pregnancies_____
- Children_____
- Miscarriages_____
- Abortions_____
- Vaginal discharge
- Vaginal itching
- Currently pregnant

Sleep:

Hours per night: _____Bedtime: _____ Waketime: _____

Do you have problems with: Remembering dreams Nightmares Staying asleep
Waking up in the AM Waking refreshed Falling asleep

Do you wake up at night? If yes, how often and at what times does this happen? _____
_____

Energy level (average per week, circle one): Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Sress level (average per week, circle one): Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Source(s) of stress: _____

How do you cope with stress? _____

Pain level (average per day, circle one): Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Area(s) of pain:
Please list all ares of pain: _____
_____

Current Medications:

Medication Name	Prescribed By	Dosage

Any further information relevant:

_____
_____
_____
_____
_____

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No-Show and Late Cancellation Policy and Procedure

We do understand that unexpected emergency events may occur and you may need to cancel your appointment. Please provide at least 24 hours notice in such cases and reschedule your appointment as soon as possible.

Please understand that schedules fill up very quickly and your appointment is reserved especially for you. Failure to show for your appointment or a cancelation with **less than 24 hours notice** means that your appointment time is left empty and another person missed out on the opportunity to be seen. We appreciate your respect and understanding.

On rare occasions we may need to reschedule your appointment due to the need for professional training, personal time or for unforeseen illness or client crisis. However, we will make every effort to give you advanced notice of these rare occurrences.

Your Agreement:

I_____ understand that my appointment is specifically reserved for me. I understand that I will be personally charged a $90.00 fee for any missed appointment/or late cancellations. I authorize LifeSource Lymph and Wellness to charge any missed and/or late canceled appointment to the following credit card:

Name on the account: _____

Type of credit card: _____

Account number: _____

Expiration date (MM/YYYY): _____

3 or 4 digit security code: _____

Date: _____

Name: _____

Signature: _____