Therapeutic Massage & Lymphedema Care

Doris Laing, LLC, LMBT, CTL-LANA
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Client Intake Form

Name: _____ Date: _____

Address: _____ Date of Birth: _____

_____ Age: _____

_____ Gender: _____

Phone (*home*): _____ (*work*): _____ (*cell*): _____

Occupation: _____ Referred By: _____

Medical History: (Please Describe)

- ❍ Abdominal Pain
- ❍ Accident
- ❍ Arthritis
- ❍ Broken Bones
- ❍ Cancer
- ❍ Decreased Range of Motion
- ❍ Stiffness
- ❍ Upper Back Pain
- ❍ Diabetes
- ❍ Disk Problem
- ❍ Heart Attack
- ❍ High Blood Pressure
- ❍ HIV
- ❍ Joint Ache
- ❍ Stroke
- ❍ Varicose Veins
- ❍ Low Back Pain
- ❍ Mid Back Pain
- ❍ Neck Pain
- ❍ Nervous Tension
- ❍ Osteoporosis
- ❍ Sprains
- ❍ Surgery
- ❍ Whiplash Seizures

Other: _____

_____

Exercise:

- ❍ Aerobics
- ❍ Running
- ❍ Walking
- ❍ Sports
- ❍ Biking
- ❍ Gym
- ❍ Swimming
- ❍ Other

Details of Exercise: _____

_____

_____

Drugs:

Medications: _____

Purpose: _____ Dosage: _____

Supplements: _____

Purpose: _____ Dosage: _____

What is your main concern or what would you like to address in your massage session?

_____

_____