Manual Lymphatic Drainage

CLIENT INTAKE FORM

Before Your First Appointment, Please Fill Out the Form

HOLISTIC A HEALING

Your data and personal information are safe with us. We never share or sell any data we receive and adhere strictly to patient-therapist confidentiality.

**Please be advised that the treatments offered should never be regarded as an alternative to orthodox medical treatment. However, they do complement other treatments. If you are currently receiving medical treatment, please consult with your physician prior to your appointment.*

Location:

Dixie & Burnhamthorpe Mississauga

DEMOGRAPHICS

Date *

Name *

First Name

Last Name

Date Of Birth *

Contact *

Phone

Email

Address *

Country

Address Line 1

Address Line 2

City

State

Postal Code

Physician's Name

Physician's Consent Required?

Yes No

Emergency Contact

Occupation

Do you enjoy your work?

Reason for Consultation / Treatment?

How are you feeling today?

Are you receiving any other therapies? If so, what are they?

MEDICAL HISTORY

Do you suffer from medical conditions of:

- ☐ Heart
- ☐ Liver
- ☐ Kidneys
- ☐ Pancreas
- ☐ Thyroid
- ☐ Nervous System
- ☐ Stomach
- ☐ Bowels
- ☐ Lungs
- ☐ Back / Spine / Joints
- ☐ Others

Please provide any details necessary to the above medical conditions.

Any current medications?

Past medications, with dates taken / prescribed?

Do you suffer from allergies related to:

- ☐ Skin
- ☐ Respiratory System
- ☐ Food
- ☐ Other

Please provide any details of your allergies, such as triggers / coping mechanisms / medications / etc.

SYSTEM ASSESSMENT

Appetite

- [ ] Good
- [ ] Poor

Meals

- [ ] Regular
- [ ] Irregular

Digestion

- [ ] Good
- [ ] Heartburn / acid reflux
- [ ] Bloating
- [ ] Other

Please provide any details, if needed, regarding your digestive health.

TYPICAL DAILY DIET

Breakfast / Lunch / Mid-Afternoon / Evening / Coffee + Tea / Alcohol

Daily Bowel Movements

- [ ] Good
- [ ] Poor

Bowel Discomfort

- [ ] Constipation
- [ ] Diarrhoea
- [ ] Pain
- [ ] Alternating
- [ ] Bloating
- [ ] Other

Please provide any details, if needed, regarding your bowel discomfort.

URINARY SYSTEM

Urinary System Concerns

- [ ] Cystitis
- [ ] Prostate
- [ ] Discomfort
- [ ] Other

Please provide any details, if needed, regarding your urinary health.

RESPIRATORY SYSTEM

Respiratory System Concerns

- [ ] Asthma
- [ ] Sinus
- [ ] Ears
- [ ] Other

Please provide any details, if needed, regarding your respiratory health.

LYMPHATIC SYSTEM

Lymphatic System Concerns

- [ ] Swollen Glands
- [ ] Sore Throats
- [ ] Swollen Ankles
- [ ] Frequent Colds
- [ ] Other

Please provide any details, if needed, regarding your lymphatic health.

CIRCULATORY SYSTEM

Circulatory System Concerns

- [ ] Good
- [ ] Poor
- [ ] Cold / Warm
- [ ] Varicose Veins
- [ ] Hypertension
- [ ] Hypotension
- [ ] Other

Please provide any details, if needed, regarding your circulatory health.

SKIN

Skin Concerns

- [ ] Normal
- [ ] Dry
- [ ] Sensitive
- [ ] Oily
- [ ] Combination
- [ ] Eczema
- [ ] Psoriasis
- [ ] Other

Please provide any details, if needed, regarding your skin health.

MUSCULO-SKELETAL SYSTEM

Musculo-Skeletal System Concerns

- ☐ Injuries
- ☐ Stiffness
- ☐ Pain
- ☐ Other

Please provide any details, if needed, regarding your muscular and/or skeletal health.

REPRODUCTIVE SYSTEM - FEMALE

Menstrual Cycle

- [ ] Regular
- [ ] Irregular
- [ ] Next Due Date

Additional Reproductive System Concerns

- [ ] Dysmenorrhoea
- [ ] Amenorrhoea
- [ ] Menopausal Difficulties
- [ ] Hot Flashes
- [ ] Other

Please provide any details, if needed, regarding your reproductive health.

NERVOUS SYSTEM

Nervous System Concerns

- [ ] Headaches
- [ ] Epilepsy
- [ ] Depression / Anxiety
- [ ] Sleep Pattern Issues
- [ ] Other

Please provide any details, if needed, regarding your nervous system health.

Stress Level

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10+

Please provide any details regarding common sources of stress in your life.

Energy Level

- [ ] Good
- [ ] Poor
- [ ] Erratic
- [ ] Fatigue
- [ ] Other

Please provide any details regarding your energy levels.

LIFESTYLE

Please describe any weekly exercise performed, if any.

What activities do you do for "time out" / personal relaxation / recreation?

Do you smoke?

- ☐ Yes
- ☐ No

Are you commonly around people that smoke?

- ☐ Yes
- ☐ No

Any other important things I should know?

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THANK YOU FOR
TAKING THE TIME TO
FILL OUT

HOLISTIC A HEALING