CHLOE FETROW THERAPY

Client Health History Form

In order to maximize the effectiveness and safety of massage sessions, please take the time to carefully fill out this questionnaire. This information will be treated confidentially.

Name: _____ Date: _____
Phone:_____ E-Mail:_____
Address:_____
Zip: _____ Date of Birth: _____
How did you hear about us? _____
Emergency Contact: _____ Phone: _____
Are you pregnant? ❑ Yes ❑ No If yes, what trimester? _____
Are you currently menstruating? ❑ Yes ❑ No
Any allergies (oils, lotions, nuts, fruit, skin, etc.) ❑ Yes ❑ No
If yes, please list: _____
Which service(s) have you experienced? ❑ Massage ❑ Acupuncture ❑ Yoga ❑ Reiki ❑ Other
Have you had Manual Lymphatic Drainage Therapy (MLD)? ❑ Yes ❑ No
For what reason are you seeking Manual Lymphatic Drainage? ❑ Medical Reason ❑ Relaxation
If medical reason, please explain: _____
Have you had any lymph nodes removed? ❑ Yes ❑ No
If yes, please describe: _____
Are you currently under medical supervision or receiving medical interventions? ❑ Yes ❑ No
If yes, please describe: _____
Do you have a Pacemaker? ❑ Yes ❑ No
Current medication you are taking including non-prescription:
_____
_____

Please list any NON-COSMETIC surgeries, accidents, and/or hospitalizations and dates:
_____
_____
_____

Please mark all COSMETIC surgeries and dates:

LIPOSUCTION

❑ 360 _____
❑ Abdomen _____
❑ Waist/Flanks _____
❑ Arms _____
❑ Hips _____
❑ Thighs _____
❑ Neck/Chin _____

BREAST

❑ Augmentation _____
❑ Removal _____
❑ Reduction
❑ Lift _____

OTHER

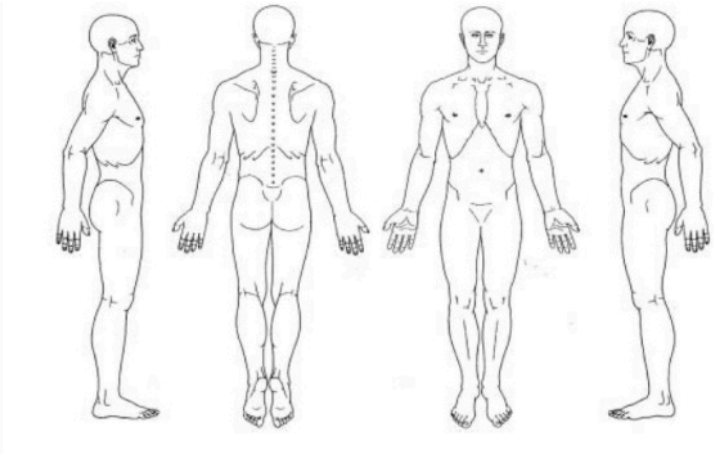
❑ Abdominoplasty (Tummy Tuck) _____
❑ Brazillian Butt Lift (BBL) _____
❑ Face Lift _____
❑ Neck Lift _____
❑ Rhinoplasty _____
❑ Hip Augmentation _____

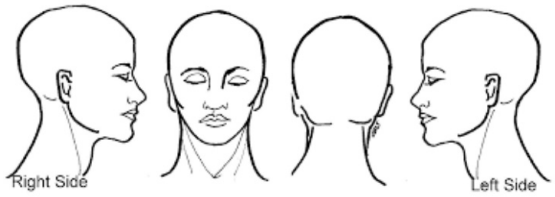
Surgeon Name: _____ Contact Phone: _____

Please check if any of the following are relevant to your **current and past** medical history.

- ❑ Area(s) of swelling
- ❑ Anxiety
- ❑ Autoimmune disorder
- ❑ Back/neck problems
- ❑ Bleeding disorder
- ❑ Blood clots
- ❑ Bruise easily
- ❑ Cancer
- ❑ Cesarean section (C-section)
- ❑ Contagious condition
- ❑ Decreased sensation
- ❑ Diabetes
- ❑ Difficulty sleeping
- ❑ Edema
- ❑ Fibromyalgia
- ❑ GI disorder
- ❑ Heart condition
- ❑ Herniated disc
- ❑ Hypertension
- ❑ Hypotension
- ❑ Kidney disease
- ❑ Lyme disease
- ❑ Lipidema
- ❑ Lymphedema
- ❑ Multiple Sclerosis
- ❑ Migraines/headaches
- ❑ Neurological condition
- ❑ Neuropathy
- ❑ Osteoarthritic
- ❑ Osteoporosis
- ❑ Pain Syndrome
- ❑ Phlebitis
- ❑ Rash
- ❑ Sciatica
- ❑ Seizures
- ❑ Sinus problems
- ❑ Skin conditions
- ❑ Soft tissues issues
- ❑ Stress
- ❑ Stroke
- ❑ Surgical implant
- ❑ Tendonitis
- ❑ Thyroid disorder
- ❑ TMJ disorder
- ❑ Varicose veins
- ❑ Vertigo/dizziness

Please indicate the areas where you have pain or other symptoms.





For how long have you experienced pain/discomfort/symptoms in the indicated areas?:

_____

Describe what you do that causes pain, and what activities make it worse:

_____

Does your therapist have permission to contact your physician or surgeon?: ❑ Yes ❑ No

Is there anything else that your MLD therapist should know about you or your needs before the session?: _____