Fluid Motion Massage Client Intake Form

Name: DOB:

Phone #: Email address:

Address: City/State/Zip:

Occupation:

Emergency contact: Phone #:

Have you had a lymphatic massage in the past?  YES  NO

How did you hear about Fluid Motion Massage?

What is your goal for this massage?

Please check all that apply:

Skin conditions- rash, hives, skin cancer, eczema, psoriasis

Cosmetic surgery Location/type of surgery:

Acute infection cellulitis

Acute inflammation Location:

Chronic inflammation Location:

Blood clot/DVT in past 6 months Location:

Pulmonary Embolism

Cancer history Location/Date/treatment received?

Wounds

Kidney failure/Acute or chronic kidney disease

Congestive heart failure

Pregnancy If so, how far along:

Diabetes

Orthopedic surgery Location & Date:

High blood pressure/Low blood pressure

Varicose veins

Breathing problems

Arteriosclerosis

Decreased sensation

Rheumatoid arthritis

Lipedema

Lymphedema

Chronic venous insufficiency

Fibromyalgia

Hyperthyroidism/hypothyroidism

Hernia

Inflammatory bowel disease

Diverticulitis

Cold or sinus congestion

Lyme Disease

Allergies

Pain Location: Rating: (0-10 scale) Choose an item.

Liver Disease

Other:

Please indicate areas of the body you would like to be avoided:

This massage will include light touch with rhythmic, circular, and flowing strokes. Extra time will be spent over lymph nodes/bundles. This massage is far different than your typical musculoskeletal massage. After this massage it will be normal to experience increased urination due to the cleansing, diuretic effect which helps with the elimination of toxins and waste from your system. This massage is relaxing, therapeutic and induces an analgesic effect. Please feel free to speak up throughout the session if anything is bothering you. Depending on your goals for the massage, active ROM of a joint or diaphragmatic breathing may be encouraged. Lay back, relax and enjoy!

**Informed Consent:** The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain, dizziness, or shortness of breath during my session. I understand that no inappropriate comments or conduct sexually suggestive in nature will not be tolerated. Any indication of such behavior will automatically end the session with full payment expected. I agree to update the therapist regarding changes in my health and I understand that there shall be no liability on the therapist’s part should I forget to do so. I understand that I am seeking a lymphatic massage under my free will and with consent, therefore I agree to hold harmless the therapist and establishment from and against any and all liability and claims. Understanding all of this, I give my consent to receive care.

Client Signature: Date: