Health History Form

Name _____ Date: _____

Emergency Contact name and cell #_____

Address

_____

Cell phone # _____

Age _____

Are you currently under medical supervision? Yes No
If yes, please explain:

_____
_____
_____
_____

Are you currently taking any medication? Yes No
If yes, please explain:

_____
_____
_____
_____

I **CAN NOT** perform the lymphatic Breast Protocol if you have any of these **Contraindications**.
Please circle "NO" to confirm that you **DO NOT** have any of the conditions listed below.

Breast implants	NO
Acute infections such as sinusitis, bacterial infections	NO
Fever	NO
Previous tuberculosis	NO
Previous toxoplasmosis	NO
Serious circulatory problems: thrombosis, venous obstructions	NO
Major cardiac problems: LDT may increase cardiac load	NO

Cancer	NO
Pregnancy	NO
Epilepsy	NO
Any device that is implanted in your head or body like a pacemaker	NO
Do you take blood-thinning medications	NO
Acute asthma	NO

The following are precautions to the lymphatic breast protocol. Please circle YES or NO.

Removed spleen	YES	NO
Major renal insufficiency	YES	NO
Hyper or hypothyroidism	YES	NO
Carotid stenosis	YES	NO
Acute asthma and allergies	YES	NO
Fresh scars, eczema	YES	NO
Chronic infection	YES	NO
Orthostatic hypotension	YES	NO

I am aware that prescription drugs may circulate or be metabolized faster.

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist’s part should I fail to do so.

Signature of client _____ Date _____