1745 Woodstock Rd.
Roswell, GA 30075
770-642-4646

PATIENT PROFILE - THERAPY

NAME: ____**DATE:**______________________

If a Minor, Parent or Guardian name: ____

ADDRESS: ____

CELL PHONE: ____________________________ **EMAIL:**_______________________________________

Would you like to receive our Newsletter? Yes / No Who can we thank for referring you? _______________

AGE: _____ **HEIGHT:** _____ **WEIGHT:** ______ **DOB:**_________________ **Occupation:** _______________

Please list in order of importance your reasons for receiving therapy ______________________

____

List any surgeries you have had along with the dates: ____________________________________

____

Please list any medications that you are currently taking:__________________________________

____

Do you have a pacemaker? Y N

Are you pregnant or nursing? Y N

History of deep vein thrombosis? Y N

Cardiovascular conditions? Y N

Recent illness? Y N

Have you had any organ transplants? Y N

History of skin conditions or infections? Y N

History of blood clots? Y N

Recent injury or trauma? Y N

Issues with your Lymphatic system? Y N

<u>**Contraindications: Acute infections or fever; Thrombosis or blood clotting disorders; Kidney problems. Heart problems or congestive heart failure**</u>

WAIVER AND INFORMED CONSENT:

Client acknowledges that they have provided accurate health information. Client understands the potential risks and benefits of supportive therapy. Client agrees to undergo therapy based on their own decision. Client understands that the therapist may need to adjust or terminate the session based on their health status. Client releases the therapist from any liability associated with the therapy. Client acknowledges that they have been informed about contraindications.

CONSENT: I understand that none of the practitioners or the associates or staff of Longevity Health Center are medical doctors. I choose to undergo an evaluation and treatment in accordance with holistic principles.

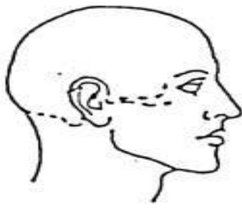
I consent to receive treatment utilizing one or more of the listed modalities: ACUPUNCTURE, FSM, MASSAGE, ASSISTED LYMPH THERAPY, THERALASE (Red Light Therapy).

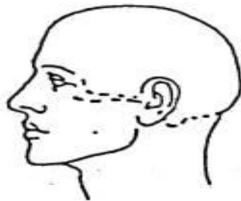
____ _________________________________

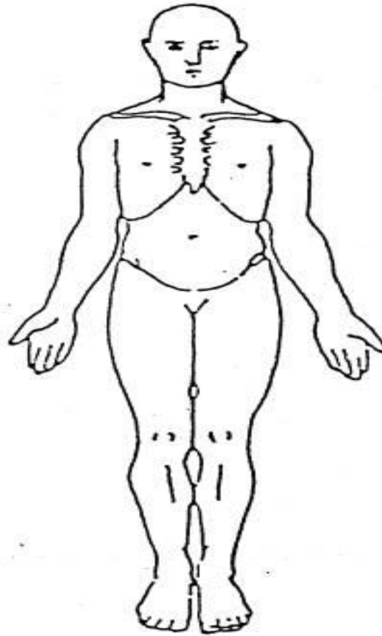
SIGNATURE **DATE**

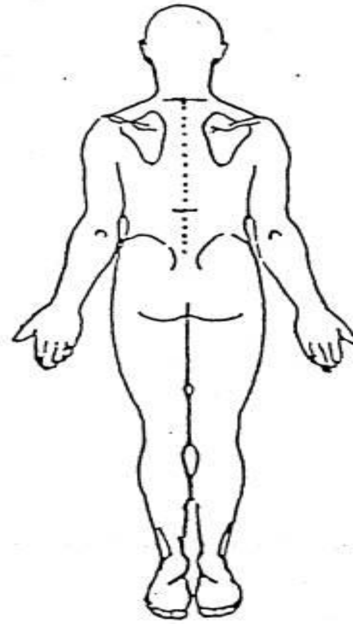
PAIN PROFILE

Mark an X to show where you have pain.









Please list the areas that you have marked above and indicate the severity of the pain.

____________________________ 1 2 3 4 5 6 7 8 9 10 Chronic / Acute

____________________________ 1 2 3 4 5 6 7 8 9 10 Chronic / Acute

____________________________ 1 2 3 4 5 6 7 8 9 10 Chronic / Acute

____________________________ 1 2 3 4 5 6 7 8 9 10 Chronic / Acute

____________________________ 1 2 3 4 5 6 7 8 9 10 Chronic / Acute

Please indicate your level of daily stress: 1 2 3 4 5 6 7 8 9 10

Please indicate your daily energy level: 1 2 3 4 5 6 7 8 9 10

Have you been diagnosed with Lymphedema? YES / NO
If so, which extremities are affected? ____________________________________

____

Have you had lymph nodes removed? YES / NO
If yes, how many and what location? ____________________________________

____