CONFIDENTIAL QUESTIONNAIRE

Name: _____

D.O.B. _____

Address: _____

Phone: _____

E-mail: _____

Occupation: _____

How did you hear about us: _____

Contraindications of Lymphatic Therapy

With any medical electronic device, the contraindications are standard. The following are a list of those who can not participate in Lymphatic Therapy unless under the direction of a licensed physician. Please inform the therapist if you have any of the following conditions. Please initial to the left of each statement indicating that you have read it.

	I do not have a pacemaker.
	I am not pregnant.
	I do not have a history of epileptic seizures.
	I do not have thrombosis (blood clots) or knowledge of having it.
	I do not have any open wounds.
	I do not have any electrical implants or neurostimulators.
	I do not have a cochlear (ear) implant.
	I do not have any hearing aids.
	I do not have aneurysm clips.
	I do not have a transplanted organ.
	Please inform the therapist if you have had/or have breast implants.
	Please inform the therapist if you are nursing.

Significant Past Illnesses:

Previous Surgeries:

Illness	Year(s)	Comments

Type of Surgery	Year(s)	Comments

Present Health Problems (please indicate current concerns and/or symptoms):

Medical Problem		Date of Onset	Comments/Concerns/Symptoms

Present Medications:

Medication Name	Date Started	Taken For

General overall health currently ⬭ Excellent ⬭ Good ⬭ Fair ⬭ Poor

*If fair or poor, please explain*_____

If you can answer "yes" to any of the 4 questions below, we cannot provide lymphatic therapy.	
Do you have a pace maker?	YES _____ No _____
Have you had any organ transplants?	YES _____ No _____
Are you pregnant?	YES _____ No _____

Additional questions		If yes, please explain in detail
Do you have chronic pain?	Yes _____ No _____	
Have you been diagnosed with any autoimmune dysfunction or disease?	Yes _____ No _____	
Do you use essential oils?	Yes _____ No _____	
Is the use of oils on your skin permissible?	Yes _____ No _____	
Do you suffer from headaches or migraines?	Yes _____ No _____	
	Yes _____ No _____	

PLEASE ANSWER ALL QUESTIONS	YES	NO
1 Do you have any close relative who has had breast cancer? Whom?_____		
2 Have you ever been diagnosed with breast cancer? (*if yes please complete below box*)		
3 Have you ever been diagnosed with any other breast disease? (fibroystic, mastitis cystic, abscess)		
4 Have you had any biopsies or surgeries to your breasts? Left or Right Date:_____		
5 Have you had any cosmetic breast surgery or implants? -If implants: Under Muscle or Over Muscle , Saline or Silicone (*please circle answer*)		
6 Do you have dense breast tissue?		
7 Have you had a mammogram in the past 12 months?		
8 Have you had abnormal results from any breast testing?		
9 Have you ever taken a contraceptive pill? If yes, How long?_____		
10 Are you still having a menstrual cycle?		
11 Did your menstrual cycle start before the age of 12?		
12 Did your menstrual cycle end after the age of 50?		
13 Is your menstrual cycle irregular?		
14 Do you experience cramping during your menstrual cycle?		
15 Do you experience heavy bleeding with your menstrual cycle?		
16 Do you have breast pain or tenderness that comes and goes?		
17 Do you have breast lumps that come and go?		
18 Do you have low libido (low sex drive)?		
19 Do you experience hot flashes?		
20 Have you ever been diagnosed with endometriosis?		
21 Have you ever been diagnosed with PCOS (poly cystic ovarian syndrome)?		
22 Have you ever been treated for infertility?		
23 Do you have any swelling in the neck or trouble swallowing?		
24 Do you have any thyroid disorders? (hypo/hyperthyroidism, Hashimoto's Grave's Disease)		
25 Do you regularly experience fatigue?		
26 Have you experienced recent hair loss?		

Have you RECENTLY had any of these breast symptoms?	RIGHT	LEFT	Subside after menstrual cycle?
Pain			Yes_____ No_____
Tenderness			Yes_____ No_____
Lumps			Yes_____ No_____
Change in breast size			Yes_____ No_____
Areas of skin thickening or dimpling			Yes_____ No_____
Secretions of the nipple			Yes_____ No_____

Liability Waiver

I hereby acknowledge under oath that I am the client of Purposefully Well and I hereby give my permission to participate in Lymphatic therapy and any other services offered by Purposefully Well.

As an integral part of such permission, I recognize that ALT is an alternative therapy whose purpose is to not diagnose, heal, or cure; but to help promote good health and well-being for the mind, body and soul.

Therefore, I hereby agree to hold Purposefully Well harmless from and against any, and all claims, demands, liabilities, actions, causes of action, damages, and/or expenses, of any nature of and kind without limitation, arising from my direct or indirect participation in any of the therapies. I hereby acknowledge that I assume the risks of any and I will assume all damages if ever needed. I waive any cause of action that I might have at any time against Purposefully Well or that I might thereafter accrue as a result of any therapeutic services.

I have had an opportunity to review this waiver and ask any questions concerning its meaning or intent. I verify that I have read this entire document, have had reasonable opportunity to ask questions concerning its application, understand its contents and acknowledge that the various information provided throughout this document is accurate and complete.

I further acknowledge and verify that I have full legal authority to execute this document and there are no requirements, conditions, or obligations, legal or otherwise, which would require the consent o assent of any other personal or entity.

Client Signature_____

Date_____

All Purposefully Well ALT Therapists are trained and certified by Rightway Health & Wellness, & Dr Jennifer Gramith ND. Tonya Machado & Purposefully Well makes no claims regarding the diagnosis of an individual, the curing or healing of an individual, nor attempts to mislead an individual regarding their health and well-being.