LYMPH-OLOGY
The Art of Lymphatic Enhancement

True Wellness
A European Biological Clinic

Client Information Form: Lymphatic Enhancement Therapy. Please fill out ALL applicable information.

Items marked with an asterisk are essential for us to know prior to having Lymphatic Enhancement Therapy.**

Date: _____/_____/_____

Name_____ DOB_____/_____/_____

Gender: M_____F_____ Marital Status: (Please Circle) Single Married Separated Divorced Widowed

Address:_____City:_____
State:_____Zip:_____ Email: _____ ___

Home Phone: (_____)_____ Cell Phone: (_____)_____

Are you currently a True Wellness Client? Y / N If not, How did you hear about us?_____

Occupation: _____

Please check off any of the following conditions or symptoms which apply to you now OR in the past:

____ High Blood Pressure	____ Blood Clots**	____ Joint Pains
____ Diabetes	____ Low Blood Pressure	____ Arthritis
____ Anxiety	____ Sinus Pressure/ Congestion	____ Congestive Heart Failure**
____ Insomnia	____ Allergies	____ Unexplained Calf Pain**
____ Constipation	____ Headaches	____ Muscle Pains / Muscle Strains
____ Diarrhea	____ Tinnitus (ringing in ears)	____ Heart Attack / Stroke
____ Water Retention (Edema)	____ Low Energy / Fatigue	____ Prostate Problems
____ Breast Tenderness	____ Frequent Urination	____ Skin Infections**

Do you have any implanted electrical devices in your body: Pacemaker, ICD, Medicine Pump? **This is essential knowledge if you intend to have Lymphatic Enhancement Therapy with the Lymphstar Pro / Aria LET.**

Yes / No If yes, what kind?_____

Women: ** Are you currently pregnant? Yes / No **Are you currently breastfeeding? Yes / No

**Do you have breast implants? _____If yes, age of implants?_____

**Have you received botox injections and/or other cosmetic injections within the last 3 months? Yes / No

**Are you currently under the care of a physician for a diagnosed medical condition? Yes / No If yes, please explain.

_____

_____

Client Information Form (Lymphatic Enhancement Therapy)

Please fill out ALL applicable information.

**Do you have a history of cancer? Yes / No If yes, please explain? _____

**Did you have Chemo-therapy or Radiation to treat your cancer? Yes / No

Do you have root canals? Yes / No
Do you have amalgams (silver fillings)? Yes / No
Do you have dental implants? Yes / No

Have you ever had surgery? Yes / No If yes, what type? (Please list all surgeries & dates). For additional space, please use back of this form.

_____

_____

Do you exercise? Yes / No How many times per week?_____
Types of exercise?_____

How many ounces of water do you drink per day?_____

Please list any prescription medications or nutritional supplements/ vitamins/ herbs you are currently taking_____

_____

_____

Please list and explain any other conditions/symptoms not previously mentioned in this form that concern you and important for us to know:

_____

_____

I have completed this health form to the best of my knowledge. I understand that Lymphatic Enhancement Therapy is a therapeutic health aid and does not take the place of a physicians care when indicated. I have been given instructions by the Lymphatic therapist and/or signed the Lymphatic Enhancement Therapy consent form informing me about the possible detoxification (cleansing effects) of lymphatic (ARIA L.E.T.) and photonic therapies (Eclipse LED light). I understand that such effects may be of concern for one to three days following the therapy session. I will call the office during business hours if I have any concerns after the Lymphatic Enhancement Therapy session.

Name: (Please Print) _____

Signature: _____ Date: _____/_____/_____