



FIRST VISIT QUESTIONS:

Name

Address

City

Zip

Phones:

Cell:

Home:

Work:

Email:

My policy is that you must give me 48 hours of cancellation/reschedule notice to avoid full charges for treatment being due.

How did you learn of Body Cleanse Lymph Release?

Who referred you? _____

PLEASE ALSO TELL ME:

YES NO

Do you have any contagious skin conditions? (toe fungus, scabies, ringworm, etc.) _____

Are you pregnant? Or are you a nursing mother? (potential contraindication) _____

Do you have a pacemaker that is disturbed by microwaves? (potential contraindication) _____

Do you have congestive heart failure, pulmonary edema,
or throwing up blood?(potential contraindication) _____

IF YES TO ABOVE, PLEASE NOTIFY US PRIOR TO YOUR TREATMENT

Do you wear a hearing aid or any other electronic devices? _____

Do you have any known blood clots, deep bruising, or phlebitis? _____

Do you take any heart-regulating medications, for example,
heart arrhythmia or high blood pressure medication? _____

Have you had a stroke? (potential contraindication) _____

Do you have cancer? _____

If so, have you spoken with your doctor(s) or other therapists
about your coming for lymphatic release? _____

Have you ever had chronic constipation or diarrhea? _____

Are you currently experiencing constipation or diarrhea? _____



	YES	NO
Are you currently experiencing any digestive problems?	_____	_____
Are you doing any kind of body cleanse? (e.g. psyllium-based or magnesium-based colon cleanse, lymph cleanse, liver cleanse, etc.)	_____	_____
Are you planning a colonics or enema for after this treatment?	_____	_____
Do you have a root canal that is still in your mouth?	_____	_____
Do you have any aches and pains now? Where?	_____	_____
How much water you drink day, on average?	_____	
How much exercise do you do a week, on average?	_____	
How many years old are you today?	_____	

PLEASE EXPLAIN HISTORY/ISSUES BELOW (talking points): Do you have any other ongoing health issue? What inspired you to come for Lymphatic Release? Do you have any other specific health goals that you would like to attain? What surgeries have you had? E.g. tonsillectomy, appendectomy, cesarean, etc. Pregnancies?

As we work together, be sure to let us know as you notice changes.

While every consideration is made to ensure your optimal results, your follow up is essential to the complete success of this work.

I will immediately inform the therapist if I feel uncomfortable at any time, for any reason, with the treatment given me. I have been informed of potential risks and *potential contraindications* (above) and I agree to follow up as instructed. I am willing to take responsibility for my own healing and agree to hold harmless Body Cleanse Lymph Release, LLC or Margo Covington from any liability. I understand that there is currently no New Mexico State licensure for this work, and that all information is confidential unless the information is authorized verbally or in writing, or by law.

Name

Date