LYMPH IN MOTION BY CRISELDA WHITE

Body Contouring & Lymphatic Intake Form

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SECTION 1: CLIENT INFORMATION

Full Name: _____
Date of Birth: _____
Phone: _____
Email: _____

Emergency Contact Name & Phone:

SECTION 2: MEDICAL HISTORY

Check all that apply:

☐ High Blood Pressure
☐ Diabetes
☐ Heart Disease
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Disorder
☐ Cancer (Type/Date): _____
☐ Blood Clots / DVT
☐ Lymphedema
☐ Lipedema
☐ Chronic Venous Insufficiency
☐ Autoimmune Disorder

☐ Neuropathy
☐ None

Medications (especially blood thinners):

SECTION 3: SURGICAL HISTORY

Have you had surgery? ☐ Yes ☐ No

If YES:

Type: _____
Date: _____
Surgeon: _____

Complications:
☐ Seroma ☐ Fibrosis ☐ Infection ☐ Delayed Healing ☐ None

Cleared by surgeon? ☐ Yes ☐ No

SECTION 4: BODY CONTOURING GOALS

Areas:

☐ Abdomen ☐ Flanks ☐ Back ☐ Arms ☐ Thighs
☐ Chin/Neck ☐ Glutes ☐ Other: _____

Goals:

☐ Fat Reduction
☐ Skin Tightening
☐ Fibrosis Reduction
☐ Swelling Reduction
☐ Post-Op Recovery
☐ Cellulite Reduction

SECTION 5: CONTRAINDICATIONS

☐ Pregnancy
☐ Pacemaker / Metal Implants
☐ Active Cancer
☐ Open Wounds
☐ Infection
☐ Hernia
☐ Severe Varicose Veins
☐ Recent Surgery (<2 weeks)
☐ None

SECTION 6: LIFESTYLE

Water Intake: ☐ <1L ☐ 1–2L ☐ 2–3L ☐ 3L+
Exercise: ☐ None ☐ 1–2x ☐ 3–5x ☐ Daily

Diet: ☐ High Salt ☐ High Sugar ☐ Balanced ☐ Other: _____

SECTION 7: PREVIOUS TREATMENTS

☐ MLD ☐ Cavitation ☐ RF ☐ Vacuum ☐ EMS ☐ Wood Therapy

Reactions: _____

SECTION 8: BASELINE MEASUREMENTS (THERAPIST)

Abdomen: _____
Waist: _____
Hips: _____

Thigh R/L: _____ / _____
Arms R/L: _____ / _____

Photos Taken: ☐ Yes ☐ No

SECTION 9: INFORMED CONSENT

I understand:

- Services are non-medical
- Results are not guaranteed
- I must follow aftercare
- I disclosed all conditions truthfully

Signature: _____ Date: _____

SECTION 10: PHOTO CONSENT (OPTIONAL)

☐ Documentation only
☐ Marketing use (optional discount)

Signature: _____

SECTION 11: SOAP NOTE (INTERNAL USE)

S – Subjective:

O – Objective:

A – Assessment:
☐ Swelling ☐ Fibrosis ☐ Fluid Retention ☐ Circulation Issue

ICD-10 OPTIONS

- I89.0 – Lymphedema
- R60.0 – Edema
- E88.2 – Lipedema
- I87.2 – CVI
- L90.5 – Scar/Fibrosis

PLAN

☐ MLD ☐ Cavitation ☐ RF ☐ Vacuum ☐ EMS ☐ Red Light

Frequency: _____
Duration: _____

SECTION 12: TERMS, CONDITIONS & POLICIES (REQUIRED)

APPOINTMENT POLICY

_____ 24-hour notice required for cancellations

_____ Late cancellation = loss of session or full charge

NO-SHOW POLICY

_____ No-show = full charge or session forfeited

_____ Repeated no-shows may result in denied booking

LATE POLICY

_____ Late arrival shortens session

_____ 15+ minutes late = cancel or reduced session (no discount)

REFUND POLICY

_____ All sales final (packages, memberships, prepaid)

_____ No refunds once services begin

_____ If 1 session used → up to 50% refund (management discretion)

_____ Multiple sessions used → no refunds

PACKAGE POLICY

_____ Non-transferable

_____ Must follow recommended schedule

_____ Unused sessions are non-refundable

POST-OP RESPONSIBILITY

_____ Must have surgeon clearance

_____ Must follow compression & aftercare

_____ Non-compliance affects results

SCOPE OF PRACTICE

_____ No incisions opened or drained

_____ Services are within Texas LMT scope

RESULTS DISCLAIMER

_____ Results vary (no guarantees)

PAYMENT POLICY

_____ Payment due at time of service

_____ Missed payments may pause services

FINAL AGREEMENT

I have read, understood, and agree to all terms.

Client Name: _____

Signature: _____

Date: _____