Luminary BEAUTIES

INTAKE FORM

Name

Date of Birth

Phone Number

Email

Address

Do you exercise? Yes No If yes, how many times per week ? _____ How many hours? _____

**Please mark any of the following conditions you may currently have.

- Neck injury
- Infection
- Pms
- Emotional changes
- Sinus congestion
- Headaches
- Cold virus
- Flu
- Allergies
- Alcohol within 24hrs
- Kidney alignment
- Sports injury
- Phlebitis
- Bruises
- High Blood pressure
- Varicose veins
- Acute pain
- Grief process
- Recent surgery
- Open wounds
- Osteoporosis
- Chronic pains
- Blood clot
- Fever within 24hrs
- Wear contacts
- Others, please specify

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**For manual lymphatic drainage clients only

- Pregnant
- Surgery within one year
- Give birth within one year
- History of DVT
- Cardiac edema
- Acute infection
- Acute bronchiot
- Renal failure
- Small / Large intestine
- Inflammation Exposed to radiation fibroses
- Exposed to radiation cystitis
- Explained pain
- Neck dissection
- Carotid endarterectomy
- Carotid sinus syndrome
- Cardiac Arrhythmia
- Medication for hyperthyroidism
- Congested heart failure
- History of CBA
- Others, please specify

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I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment nor perfom spinal manipulations. I will inform the therapist of my current condition at the time of each visit.

Signature _____