

First Name: _____ Last Name: _____

Your Health

Date: _____

1. Have you been under Physician care within the last year? If so, why? Yes No
_____2. Have you been referred by a Physician to us? If so, why? Yes No

3. Physician Name and Contact Info: _____

4. List all medications that you take regularly: _____
_____**Please check YES or NO. Please explain any Yes answers!**

Y____N____ Allergies: _____

Y____N____ Asthma: _____

Y____N____ Bronchitis: _____

Y____N____ Cancer: _____

Y____N____ Cardiac Edema: _____

Y____N____ Congestive Heart Failure: _____

Y____N____ Deep Vein Thrombosis: _____

Y____N____ Infection: _____

Y____N____ Carotid Sinus Syndrome: _____

Y____N____ Cardiac Arrhythmia: _____

Y____N____ Stroke: _____

Y____N____ Abdominal Surgery: _____

Y____N____ Aortic Aneurysm: _____

Y____N____ Crohn's Disease, Colitis: _____

Y____N____ Abdominal Surgery: _____

Y____N____ Diverticulitis: _____

Y____N____ Abdominal Surgery: _____

Y____N____ Unexplained Belly Pain: _____

Client Signature: _____ Date: _____

Based on my history and current condition, I am a candidate for Breast MLD and hereby provide consent for The Body Works! therapist to offer the treatment.

Client Signature: _____ Date: _____