

**The Lane Center for Natural Healing**  
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## *Lymph Drainage Intake Form*

Name:	Home Phone:	
Address:	Business Phone:	
	Mobile Phone:	
Date of Birth:	Email:	
Occupation:	Referral Source: May we thank your referral source?	
Have you had Lymph Drainage before? Yes/No (circle one) If yes, when?		
General stress level is (circle): Very High / High / Moderate / Low		
Do you have (or have you had recently) any of the following? (please check all the apply)		
<input type="checkbox"/> Surgery	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin condition specify:
<input type="checkbox"/> Injury	<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Cuts/sores where:
<input type="checkbox"/> Recent physical trauma (car accident, etc.)	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Phlebitis/blood clots	<input type="checkbox"/> Disc or spine injury	<input type="checkbox"/> Surgical implant
<input type="checkbox"/> Cancer	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Foot conditions specify:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pain/numbness/tingling (circle) where:	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Other	
Please explain any major conditions above, or any other medical conditions you may have:		
Are you currently taking any medications? Please specify:		
Do you have limited movement in any joints? If so, where?		
Do you have sensitivity to touch or discomfort with touch in any area? (emotional or physical)		
What is your main reason for seeking Lymph Drainage?		
Any Allergies?		
Are you wearing contact lenses? Yes / No		
<b>Signature:</b>	<b>Date:</b>	