LYMPHATIC ENHANCEMENT THERAPY
Demographics and Consent for Sessions

_____ _____ _____
first name *last name* *date of birth*

_____
mailing address

_____
primary phone *email address*

Please list any recent major medical concerns, any treatment you are currently receiving, and any major surgeries or injuries you've had. Also, any pertinent health concerns.

_____
_____
_____
_____

Please list any prescriptions and supplements you take regularly.

_____
_____
_____

Please read and initial each highlighted point below

_____ ***IT IS HIGHLY RECOMMENDED THAT YOU ARE WELL HYDRATED AFTER YOUR VISIT, AS WELL AS BEFORE, IF POSSIBLE, TO PREVENT DETOX SYMPTOMS.***

_____ ***WOMEN WHO ARE PREGNANT ARE WELCOME TO HAVE THIS WORK DONE AFTER THE BABY ARRIVES.***

_____ ***IF YOU HAVE ANY INJECTIBLES SUCH AS BOTOX, JUVEDERM, OR FILLERS, YOU MUST INDICATE THIS PRIOR TO THE SESSION STARTS WHERE INJECTIBLES ARE LOCATED. THIS INCLUDES PLACES OTHER THAN THE FACE.***

____ ***IF YOU HAVE BREAST IMPLANTS, HEARING AIDS, A PACEMAKER, OR ANY OTHER IMPLANTED MEDICAL DEVICE, INDICATE THAT PRIOR TO YOUR SESSION.***

Consent for Care

I understand that Lymphatic Enhancement Therapy is for improving lymphatic flow. I have stated all my known medical information and understand that it is my responsibility to keep my lymphatic enhancement practitioner informed of any changes in my health, and of any medications I any take in the future. I also understand that lymphatic enhancement therapy is not a substitute for medical treatment and that I should see a doctor / health care provider for diagnosis and treatment for any suspected medical problem.

_____
Signature Date

_____
Lori Hirshman- LET Practitioner Date