All Is Well Holistic Spa

Lymphatic Massage Consent Form

Today's Date: _____

Client Information:

- Full Legal Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____
- Email: _____
- Emergency Contact (Name & Phone): _____

Health History
Please check any conditions you have or have had:
☐ Abdominal pain ☐ Allergies ☐ Cancer (Last treatment date: _____)
☐ Cardiovascular issues ☐ Autoimmune disorders ☐ Blood Clots
☐ High/Low Blood Pressure ☐ Pregnancy (If high-risk, please provide doctor's permission)
☐ Other: _____

Reason for Seeking Lymphatic Massage Today:

Medical Permissions (If Applicable)

- Are you currently undergoing cancer treatment? ☐ Yes ☐ No
  - If **Yes**, do you have written permission from your treatment team? ☐ Yes ☐ No
- Are you pregnant and/or have a high-risk pregnancy? ☐ Yes ☐ No
  - If **Yes**, do you have written permission from your OB? ☐ Yes ☐ No

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Informed Consent
I understand that:

- Lymphatic massage is not a substitute for medical treatment.
- Certain conditions may require medical clearance.
- I have disclosed all relevant health information truthfully.
- I consent to the session and understand the risks involved.

HIPAA Notice: I acknowledge that All Is Well Holistic Spa follows all HIPAA regulations and will protect my personal health information. My information will not be shared without my consent.

Client Signature: _____
Date: _____

Therapist Signature: _____
Date: _____