Low Level Laser
Kylie Fletcher
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Client Consultation Form

This information is completely confidential and is only used for the purpose of this diagnosis.

Client Details

Full Name:________________________ Date of Birth:_____________________________
Address:_________________________ Suburb:_________________________________
State:____________________________ Post Code: ______________________________
Occupation: ______________________
Phone:(Home)_________________ (Work)_______________ (Mobile)_________________
Email:____

Case History

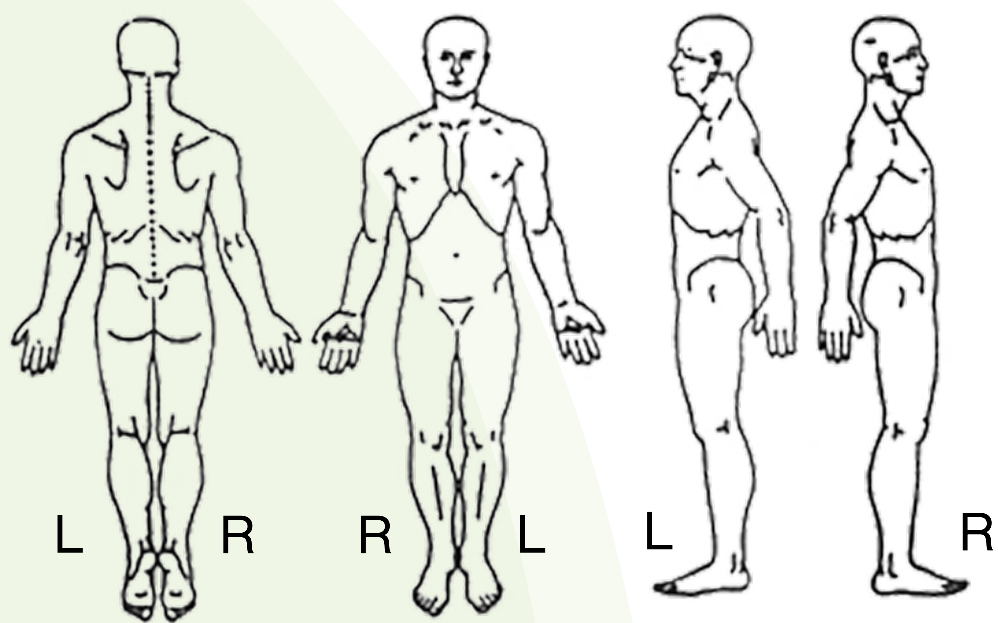
1. Are you on any medication(s)? ☐ YES ☐ NO

If yes what kind?____

2. What is the main reason for your visit? E.g. pain relief, relaxation, stress:

____
____
____
____
____
____

3. Please place a number on the body area that you receive pain on the picture below, the number should be between 1 and 10 and reflect how intense the pain is on an average day (1 being very little and 10 being severe)



4. How long has this type of pain been a problem? E.g.1 wk, 1 month etc:

____

____

5. How did you hear about Lymph Drainage Therapy?
E.g. friend/family, car advertisement etc:

____

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6. To ensure that you receive the best possible treatment and the desired outcome is met, can you please tick below “past or present” if the conditions apply to you currently, or at some stage in your past.

PAST	PRESENT	
☐	☐	Dislocation, if yes which body part, e.g. left shoulder
☐	☐	Skin condition/Area of broken skin
☐	☐	Whiplash
☐	☐	Surgery
☐	☐	Spain/bruises
☐	☐	Infectious diseases
☐	☐	Varicose Veins
☐	☐	Abnormal swelling
☐	☐	Arthritis
☐	☐	Fracture
☐	☐	Any form of cancer (Location of cancer__________ Date cleared____________) Is this within 5yrs ☐ Yes ☐ No Drs letter required ☐ Yes ☐ No
☐	☐	Any undiagnosed severe pain

7. Please list any other past or present medical conditions, injuries, illness, allergies or problems if they are not listed above:

____

____

8. Are you pregnant? ☐ YES ☐ NO
If yes how far into the pregnancy?____

9. Are you currently with a health fund? ☐ YES ☐ NO.
If yes who is your health fund?____

Additional information entered by Massage Therapist regarding client's history if applicable

____

____

____

Cancellation Policy:

If less than 24hours of notice is given half of the treatment cost is billed to the client in question and if no notice is given then the full price of the treatment is billed. This is up to Lympth Drainage Therapy discretion whether or not the signing client is billed if the above occurs

I __________________ declare that all the information that I have provided in this personal record is true and complete. A Massage Therapist must be aware of all past and present physical conditions; I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my physical health during any treatments.

I agree with the terms of the cancellation policy listed above:
Signature:_____________ Date:_______________

Digital Signature: ☐ I accept ☐ I decline Date:_________________

I give permission for Kylie Fletcher to use Low Level Laser therapy and sign that I don't have any of the contraindications listed below.

- Pregnancy.
- Cancer.
- Fever (body temperature >38°c).
- Acute local & systemic infections.
- Haemorrhages.
- In the vicinity of pacemakers.

Signature:_______________ Date:__________________

Digital Signature: ☐ I accept ☐ I decline Date:_________________

For Lymphoedema or Lipoedema patients only

1 How soon after surgery did your lymphodema first occur? ______years ago
______years after surgery

2 Did you have an accidental or an illness right before the onset of the Lymphoedema or Lipoedema?

☐ Yes
☐ No

If Yes, specify ____________

3 Did your ever have a skin on the oedematous limb?

☐ Yes
☐ No

If Yes, what _____________

4 If Yes, did you take antibiotics?

☐ Yes
☐ No

5 Have you ever taken dicuretics as part of your Lymphodema or Lipoedema treatment?

☐ Yes
☐ No

6 Have you taken any other medication for Lymphoedema and Lipoedema?

☐ Yes
☐ No

If Yes, what ____________

7 Does anyone in your family had Lymphoedema or Lipoedema?

☐ Yes
☐ No

8 Where did your oedema first occur?

☐ Upper arm ☐ Upper leg ☐ Forearm
☐ Lower leg ☐ Hand ☐ Foot

9 How has the Lymphoedema or Lipoedema been treated so far:

- ☐ Compression Garment Class ______
- ☐ Mechanical Pump
- ☐ Manual Lymph Drainage
- ☐ Compression Bandaging
- ☐ Drugs
- ☐ Surgery

10 Do your suffer from any other illness, for example:

- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart failure
- ☐ Kidney failure
- ☐ Other:_________

11 What medication are you currently taking?

____

12 Did you recive radiotherapy tratment? ☐ Yes ☐ No

13 Did you undergo chemotherapy? ☐ Yes ☐ No

14 What sort of exercise/sport do you do on a regular basis?
At present_______________________________
In the past _______________________________

15 Have you had any other operation?

____
____
____
____
____
____

16 Please sign all this information is correct ???

____

When did pain start?____

Intensity of pain?____

Wound healing problems aftet surgery? ☐ Yes ☐ No

Ulcers? ☐ Yes ☐ No

Functional problems: ☐ Yes ☐ No

If yes where?

Shoulder (Hip) ☐

Elbow (Knee) ☐

Wrist (Ankles) ☐

Current Discomfort: ☐ Yes ☐ No

What kind:______________________

During the day:__________________

At night:________________________

Psychological problems: ☐ Yes ☐ No

Endurance levels: ☐ Yes ☐ No

Restrictions of everyday activities: ☐ Yes ☐ No

What is worse? ☐ Oedema ☐ Functional Restrictions

Therapist Code____________________

TREATMENT PROTOCOL

PATIENT____________________ CODE________________________

DIAGNOSIS____________________ THEAPISTCODE____________

Fibrosis Radiation Edema Scars

Tick boxes to indicate how intensively you treated each area (one box = light; five boxes = very intensive)

1. neck	☐ ☐ ☐ ☐ ☐
2. healthy chest	☐ ☐ ☐ ☐ ☐
3. affected chest > healthy chest > inguinal	☐ ☐ ☐ ☐ ☐
4. UA inside > outside	☐ ☐ ☐ ☐ ☐
5. UA outside > delt, trapezius	☐ ☐ ☐ ☐ ☐
6. elbow	☐ ☐ ☐ ☐ ☐
7. lower arm	☐ ☐ ☐ ☐ ☐
8. arm	☐ ☐ ☐ ☐ ☐
9. finger	☐ ☐ ☐ ☐ ☐
9. repeat thorax	☐ ☐ ☐ ☐ ☐
10. side position: axilla > contralateral back	☐ ☐ ☐ ☐ ☐
11. side position: intercostal > paravertebral	☐ ☐ ☐ ☐ ☐
12. bandaging: short stretch	☐
long stretch	☐
partial underlayering	☐
total underlayering	☐
finger	☐
13. contralateral arm	☐ ☐ ☐ ☐ ☐

ARM LEFT - RIGHT	LEG LEFT - RIGHT	OTHER EXTRAS
PMT Breathing Pressure abdominals Unaffected axilla Unaffected chest routine Sturnam nodes Affect chest routine Odema arm tratment Lateral chest/axilla/back Intercostal intensives Side lying arm routine Scar OTHER	PMT Axilla Breathing Pressure abdominals Deep abdominal nodes Anterior trunk clearing Anterior leg routine Posterior leg routine Odema leg routine Quadratus lumborum Posterior trunk clearing Posterior leg routine Odema leg routine Back extensor Sacral soldiers Scar OTHER	PMT nose eyes ears gums sinus cheeks mouth - soft pallet shoulder hip Breathing Scar OTHER

Information and advice sheet issued:

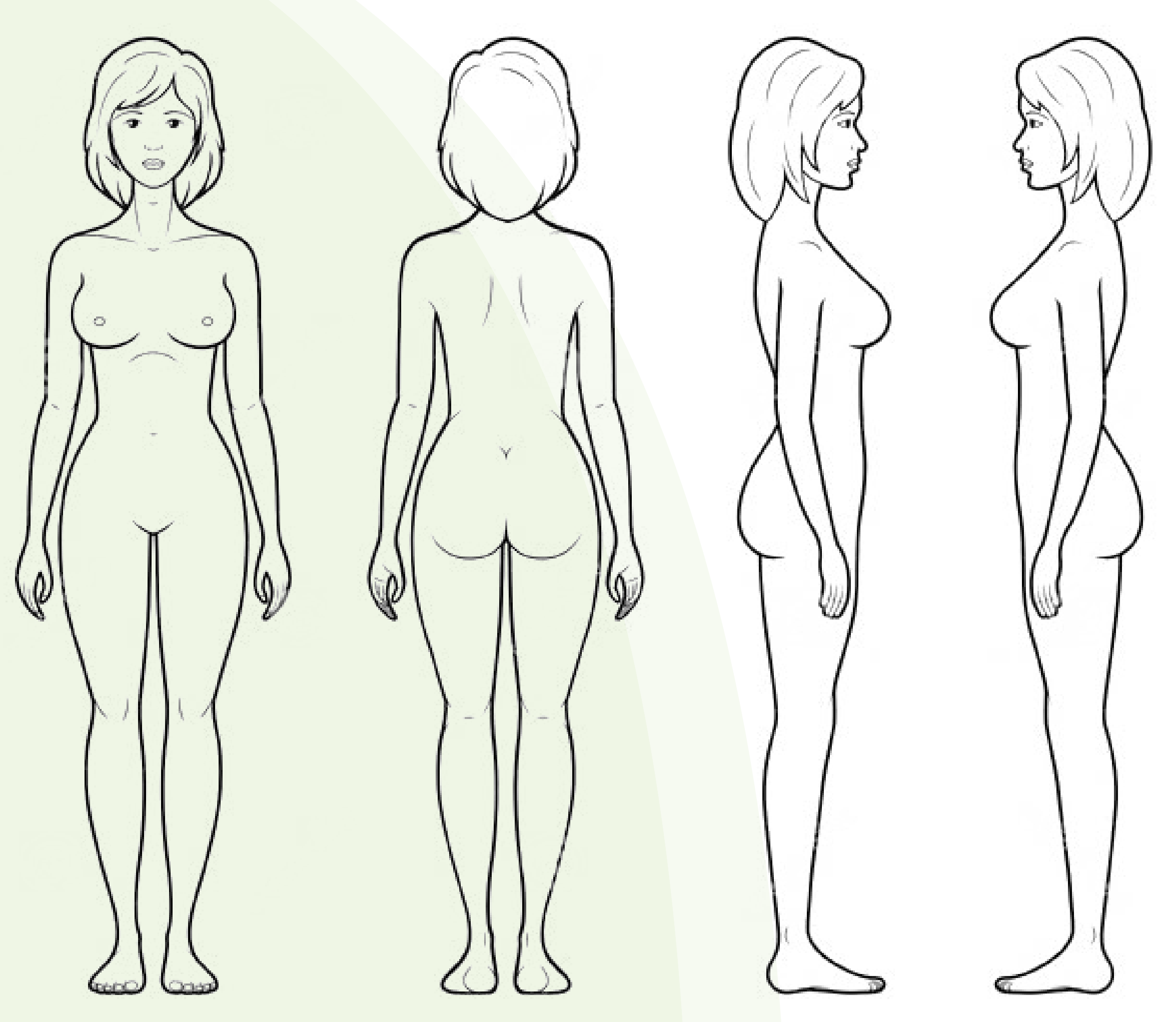
Exercises:____________________
Contra-indications_____________
Precaution:___________________

Compression garments:______________
Suppliers list:______________________
Cellulitis:__________________________

Home tratment:____

G.P/Consultant contacted?:___________________________________

ACTION:____



OEDEMA:	SCAR:	FIBROSIS:	RADIOTHERAPY FIELD:
Reduced ROM:	Altered sensation:	Bursting / Thigness:	Altered temperature:
Numbness/tingling:	Tenderness:	Acute pain/dull ache:	Skin changes:

For Lymph Drainage Therapy Use Only