FLOWpresso Client Intake

Section 1 – Personal Information	
First Name:	Cell Phone:
Last Name:	Alternate Phone:
Gender:	Email:
DOB:	Home Address:
How did you hear about FLOWpresso:	How did you hear about our Center:

Section 2 – Health History

Check all that apply and use notes section for any further explanations

☐ Congestive Heart Failure	☐ Heart Problems	☐ Cancer	☐ Acute Infection
☐ Blood Clots	☐ Low Blood Press	☐ Pregnant	☐ Other:
☐ Skin Infections	☐ High Blood Press	☐ Asthma/Breathe Respiratory Issues	☐
☐ Circulation/ Vascular Issues	☐ Pacemaker	☐ DVT – Deep Vein Thrombosis	☐

NOTES:

Have you had any surgery in the past 12 months? If so, please explain procedure & date

Are you currently on medication or under treatment from you medical doctor?

FLOWpresso

Informed Consent & Liability Release

By signing this Informed Consent & Liability Release I, _____,

Am agreeing that I have provided _____ ("The Center") with an accurate recount of my health history on the previous page and to update this center and any of its employees working with me of any and all changes to my health and wellness. _____ (initials)

I also agree that I have received a full explanation of the treatment program and any possible consequences. As with any practice involving the body a particular course of action may have varying degrees of success and the duration of the treatment to achieve a particular result. _____(initials)

This treatment does not replace any treatment currently prescribed by your doctor nor prescribed medication you are taking.

I understand it is best practice to drink lots of water, at least 8-10 glasses per day, before my therapy and one glass every hour for 6 hours following my therapy. I understand that eating properly; reducing sugar and salt to a minimum, both before and after my therapy as well as drinking appropriate amounts of water will aid my body in removing waste effectively and help to lessen the side effects of lymphatic enhancement therapies.

The Center will not be liable for any side effects, adverse reactions or lack of perceived benefits suffered by you or other consequences as the result of the treatment and you excuse The Center and all its employees from all liability.

I authorize repeat lymphatic enhancement therapies including use of manual and machine techniques, unless I specifically revoke this Informed Consent form.

I understand lymphatic enhancement therapy is contra-indicated for pregnancy or possibility of pregnancy, blood clots, DVT, congestive heart failure, pacemaker and any other medical-electrical implants, cosmetic implants and/or injections, including and not limited to breast implants and BOTOX.

I have fully read this Informed Consent and Liability Release form in its entirety and hereby execute it freely and will full acceptance and knowledge of the contents in it. I also understand that this is a legal document.