Lypossage®

Client Results

Client Number

_____

Lypossage® Sign In Sheet

Appointment #	Client Name	Date
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		

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Defining the Measurements in the Target Areas for ZONE 1

M-1: At the Navel
M-2: 1/2 way between the proximal head of the greater Trochanter and the top of the navel
M-3: At the proximal head of the greater Trochanter
M-4: 1/2 the distance up from the suprapatella toward the proximal head of the greater Trochanter
M-5: 3/4 the distance up from the suprapatella toward the proximal head of the greater Trochanter

RL means right leg and LL means left leg

NAME	CLIENT #	DATE	TELEPHONE	AGE	HEIGHT

#	M-1	M-2	M-3	RL/M-4	RL/M-5	LL/M-4	LL/M-5	Weight
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
TOTAL LOST								

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Defining the Measurements in the Target Areas for ZONE 2

R-1: 2” up from the top of the navel
R-2: 3” up from the top of the navel
R-3: 4” up from the top of the navel
RA-1: 6” up from the Olecranon
RA-2: 8” up from the Olecranon
LA-1: 6” up from the Olecranon
LA-2: 8” up from the Olecranon

The R-1 through R-3 measurements will be across the torso horizontally. The RA-1, RA-2, LA-1 and LA-2 measurements will go from the Olecranon toward the head of the Humerus.

RA means right arm and LA means left arm

NAME	CLIENT #	DATE	TELEPHONE	AGE	HEIGHT

#	R-1	R-2	R-3	RA-1	RA-2	LA-1	LA-2	Weight
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
TOTAL LOST								

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Appointment Schedule

NAME	CLIENT #

Appointments #	Date	Day	Time
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

Client Intake Form

Date:_____

Name: _____ Sex: □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Evening Phone #: _____

Social Security #: _____ Driver's License #: _____

Date of Birth: _____ Occupation: _____

Employer: _____ Employer's Address: _____

Marital Status: □ Single □ Married Email Address: _____

Children's Names and Ages: _____

Name of Spouse/Significant Other: _____

Preferred Appointment Day and Time:

Primary Health Care Provider:

Provider's Address: _____ City: _____ State: _____

Zip: _____

Telephone #: _____ Extension: _____

Permission to Consult with Primary Provider? □ No □ Yes _____ (please initial if yes)

In Case of Emergency, Please Notify:

Name: _____ Telephone #:

Relationship:

*Please note that if you are billing insurance companies, your clients will have to fill out a claim form (most likely a HCFA-1500) that duplicates most of this information.

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal
o Headaches
o Joint stiffness/swelling
o Spasms/cramps
o Broken/fractured bones
o Strains/sprains
o Back, hip pain
o Shoulder, neck, arm, hand pain
o Leg, foot pain
o Chest, ribs, abdominal pain
o Problems walking
o Jaw pain/TMJ
o Tendinitis
o Bursitis
o Arthritis
o Osteoporosis
o Scoliosis
o Bone or joint disease
o Other: _____

Circulatory and Respiratory
o Dizziness
o Shortness of breath
o Fainting
o Cold feet or hands
o Cold sweats
o Swollen ankles
o Pressure sores
o Varicose veins
o Blood clots
o Stroke
o Heart condition
o Allergies
o Sinus problems
o Asthma
o High blood pressure
o Low blood pressure
o Lymphedema
o Other: _____

Skin
o Rashes
o Allergies
o Athlete's Foot
o Warts
o Moles
o Acne
o Cosmetic surgery
o Other: _____

Digestive
o Nervous stomach
o Indigestion
o Constipation
o Intestinal gas/bloating
o Diarrhea
o Diverticulitis
o Irritable bowel syndrome
o Crohn's Disease
o Colitis
o Adaptive aids
o Other: _____

Nervous System
o Numbness/tingling
o Twitching of face
o Fatigue
o Chronic pain
o Sleep disorders
o Ulcers
o Paralysis
o Herpes/shingles
o Cerebral Palsy
o Epilepsy
o Chronic Fatigue Syndrome
o Multiple Sclerosis
o Muscular Dystrophy
o Parkinson's disease
o Spinal cord injury
o Other: _____

Reproductive System
o Pregnancy:
  o Current
  o Previous
o PMS
o Menopause
o Pelvic Inflammatory Disease
o Endometriosis
o Hysterectomy
o Fertility concerns
o Prostate problems

Other
o Loss of appetite
o Forgetfulness
o Confusion
o Depression
o Difficulty concentrating
o Drug use _____
o Alcohol use _____
o Nicotine use _____
o Caffeine use _____
o Hearing impaired
o Visually impaired
o Burning upon urination
o Bladder infection
o Eating disorder
o Diabetes
o Fibromyalgia
o Post/Polio Syndrome
o Cancer
o Infectious disease (please list)
_____
o Other congenital or acquired disabilities (please list) _____
_____
o Surgeries _____
o Other: _____

For clients who need mobility assistance, please give your
height: _____ weight: _____

Continue onto the next page…

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Health History

Continued...

Please list any additional comments regarding your health and well-being:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status. I also understand that the Lypotherapist is not a doctor and that he will only work within his scope of practice, Massage Therapy, working with muscle, pain management and relaxation. I understand that Lypossage™ is a body contouring massage treatment. I am aware that in practicing this method no attempt is made to diagnose illnesses or any other disorder and that the Lypotherapist doing the Lypossage™ Body Contouring Massage Treatment will not prescribe or perform spinal manipulations as part of the Lypossage™ Body Contouring Massage Treatment. It is further understood that I will keep my Primary Care Physician and the Lypotherapist aware of any and all physical or mental changes during the Lypossage™ Program period.

I have stated all my medical conditions and I am also aware that my Lypotherapist (Massage Therapist or Body Technician) is a Certified Lypotherapist and is not representing his or herself as an allopathic or alternative Physician (Doctor).

Client's Signature:_____Date:_____

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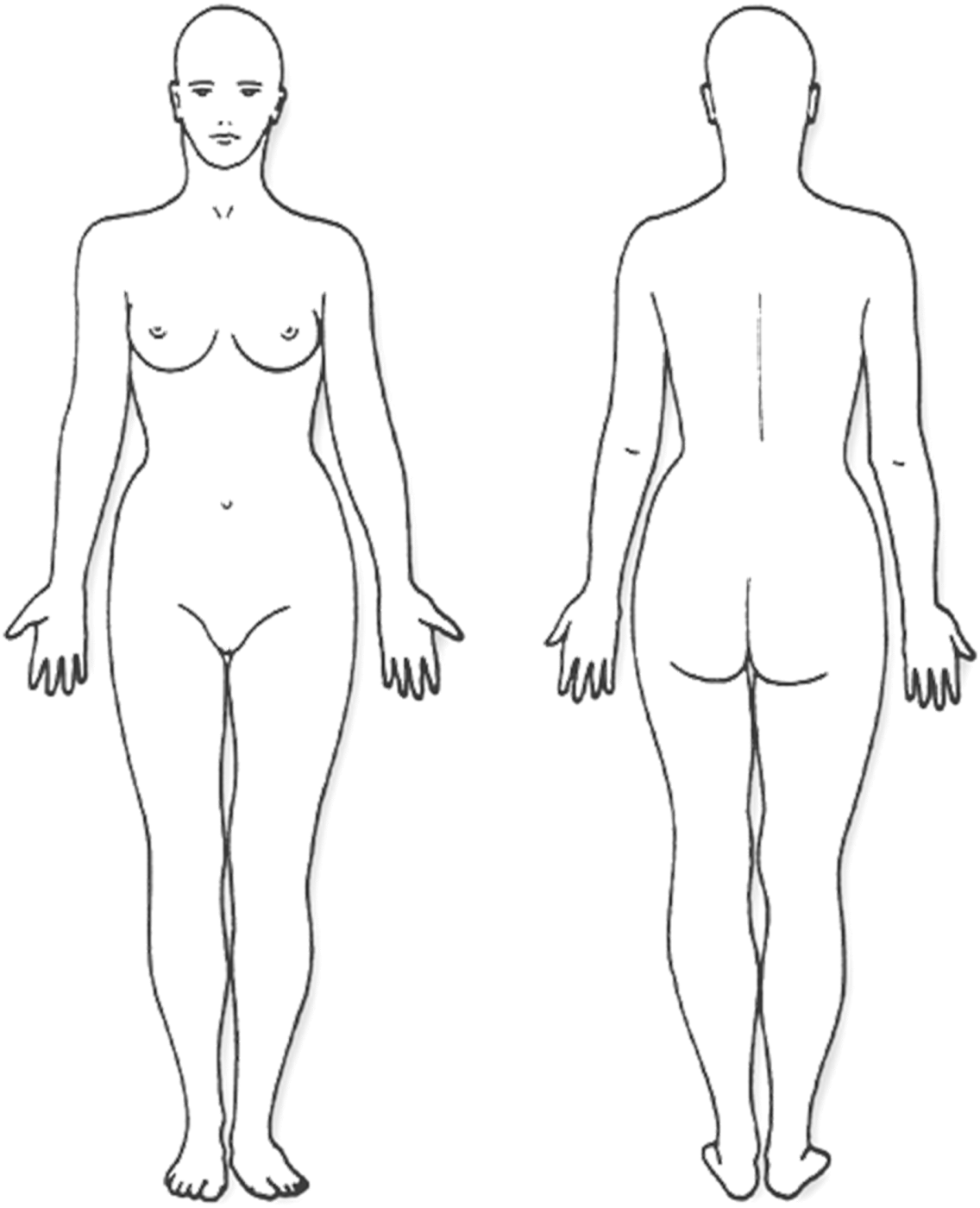
Please Circle Area of the Body That Is Of Concern



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S.O.A.P. NOTES

DATE	NOTES

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Client Release and Commitment Form

I agree to the following conditions of my Lypossage® Body Contouring Program

To keep all of my Lypossage® appointments

To do the recommended Lypossage® HomeCare

To maintain (*at least*) my normal eating habits

I consent to being photographed once every three sessions for the purpose of recording changes in the target areas

I consent to be measured every session for the purpose of recording changes in the target areas

I will report any significant health issue that may occur during the Lypossage® Body Contouring Program

I am aware that all files, photographs and measurements are the property of the Certified or Licensed Lypossage® facility

I give my permission for the Lypossage® Practitioner or licensed facility to publish statistical data and photographs derived from my Lypossage® Body Contouring Program

_____

(signature) (date)

_____Witness_____

(print name)

_____

(street address) (town) (state) (zip code)

Telephone Number:_____

What To Expect

WHAT YOU WILL WEAR

Paper Spa **THONG**

Paper Spa BRA

Wearing the same spa thong and bra each time photos are taken will keep pictures consistant. Using different color undergarments can make the person look different in photographs

WHAT TO EXPECT

- Minor Bruising
- Elimination- It is likely that after your Lypossage® treatment the you may have a bowel movement.
- Soreness

WHAT YOU SHOULD EAT BEFORE COMING TO A TREATMENT

- Refrain from eating two hours before the Lypossage® session
- Drink an 8 ounce glass of water after your Lypossage® session. This will help you to move toxins out of the body.
- During the program period, to drink at least 32 ounces of water per day.
- If you exercise please do aerobic exercise as opposed to anaerobic exercise. If you are doing weight training, you may gain dimension as you gain muscle mass. “Bulking up”, does not mean that Lypossage® is not working.