HHF (Health History Form)

How did you discover Zebra Lymphatic?

☐Internet search? ☐Word of mouth? ☐Referral?

Have you recently visited any Covid-19 hotspots? : YES/NO _____

Are you experiencing any Covid-19 symptoms eg elevated temperature/sweats? : YES/NO

_____

Date:_____ Patient name:_____

Address:_____ Post Code:_____

Phone: _____ Mobile: _____

Email: _____ Occupation: _____

Height: _____Weight:_____Sex:____ _____

Next of Kin:_____ Pension card number:_____

Date of Birth:_ _____Health Fund:_____

Referring medical doctors name:_____

Doctors address: _____ Dr's Phone: _____ Dr's Email : _____

What type of condition has your doctor diagnosed? _____

How long have you had: the diagnosis_____

Did it appear suddenly or gradually? _____

Is there a family history of your condition? _____

Recent tests/screenings supplied by patient: MRI, CT, X-RAY, ULTRA SOUND, BLOOD TEST, LYMPOSCINTIGRAPH,INDOCYANINE GREEN.

Diabetes: TYPE 1/TYPE 2 Medications/suppliments?: _____

_____

Do you suffer from?: Malignant disease, Acute inflammation, Allergies, communicable disease, open wounds, Thrombosis, Cardiac, shingles problems?_____

Have you been treated for cancer or malignant disease?_____ When? _____

What type of treatment did you receive (indicate dates)? _____

_____

Do you give permission to treat whilst you have a malignant disease; YES/NO

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Lymph Node removal? YES/NO From which location of the body?_____

Radiation? YES?NO Location?_____

Other surgeries?: _____

Pain scale: 1 2 3 4 5 6 7 8 9 10

Pain: YES/NO Mobility Issues: YES/NO _____Bursting feeling: YES/NO Increased temperature:_____

Numbness: YES/NO _____Loss of sensation:_____

Have you recently noticed any changes in: the skin _____the nails _____

Are any areas of the limb noticably: harder?_____ heavier? _____

Is there any other imformation that may be relevant to the therapist that may impact on my treatment?_____

_____

I consent to measurements, photographs to record the history of my treatment on the understanding that they are not shared with any other source with my permission.

I acknowledge that no assurance or guarantee has been provided to me as the result of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks. I accept full responsibility for any injury or damage to persons, property or animals arising out of the use of the ground, facility, equipment, pool and the actions of the undersigned. Accordingly I agree to indemnify Zebra Lymphatic, its owners, employees, independent contractors and independent therapists for monetary damages and attorney fees; and further waive all personal claims and release Zebra Lymphatic its owners, employees, independent contractors and independent therapists for any damage, injury or death sustained by me, arising out of my participation in the activities, therapies and services provided by Zebra Lymphatic or presence on or use of the premises where services are performed; and further waiver subrogation claims of insurers. As a client of Zebra Lymphatic I understand that any person I bring nonto the property enter/swim/participate at our own risk. It is my express intent that this HHF form acts also as a release and hold harmless agreement shall also bind the members of my family and all respective heirs, executors, administrators, legal representatives, successors and assigns, and shall be deemed as a RELEASE, WAIVER, DISCHARGE and covenant not to sue Zebra Lymphatic and the names releases. I understand that the therapist must be fully aware of my existing medical conditions. I have disclosed on the 'HHF'all those medical conditions affecting me . It is my responsibility to keep the therapist updated on my medical history. The imformation I have provided is true and complete to the best of my knowledge. I authorize the therapist to release or obtain imformation pertaining to my condition(s) and/or treatment to/from my other care givers and doctor as required , (such as in a medical emergency or medical referal).I have read this Health History Form and agree with all of the answers to the questions. The therapist has my permission to contact my referring doctor and I hereby give permission to do so.

Printed name: _____

Signed:_____ Date:_____

Note: Cancellations under 24 hours will be charged at the normal rate