Lymphatic Enhancement Therapy (LET)

East-West Integrated Medicine
333 S. Boulder Rd., Louisville, Co., 80027
303-444-1999 – info@nitadesaimd.com

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Client Information

Name: ____ Date: ____________________________

Address: ____

City: _________________________ State: ________________________ Zip: ______________________

Main Phone: _________________________ Alternative Phone: ________________________________

E-mail: ____ DOB: _____________________

Occupation: ____

Emergency Contact: ___________________________________ Phone: __________________________

Referred by: ____

How did you hear about us?

____

What is the reason for seeking LET?

____

Please note that LET *may* be contraindicated in clients who have a history of blood clots, unexplained calf pain, seizures, those who have congestive heart failure, implanted medical devices (such as a pacemaker), and women who are currently pregnant.

It is extremely important that you discuss any of the above conditions that may apply to you with the LET therapist *prior* to your session.

Consent for Care

I understand that Lymphatic Enhancement Therapy (LET) is for improving lymphatic flow and circulation. I have stated all of my known medical information and understand that it is my responsibility to keep my LET practitioner informed of any health and/or medication changes.

I also understand that LET is not a substitute for medical treatment and that I should see a doctor/health care provider for diagnosis and treatment of any suspected medical problem.

Signature: __________________________________ Date: ______________________________

LET Health History

Please help us give you the most benefit from your LET treatment by briefly answering the following questions.

What is your primary health concern or goal at this time?

Are you in any pain or discomfort at this time?

What is your diet like?

What types of medication or supplements do you take routinely?

How do you feel about your elimination systems (bowel/bladder/sweat/breath)?

What types of surgeries have you had?

If applicable, have you had breast implants?

Have you experienced any trauma (physical or emotional) you would like us to be aware of?

Have you had cancer? If so, what part of the body and what types of treatment did you receive?

Is there anything else you would like us to know about your current health or health history?

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Authorization for Release of Health Information

Lymphatic Enhancement Therapy (LET) is a supportive and complementary therapy for clients dealing with many different health challenges including those with a cancer diagnosis. LET is **not** a substitute for medical treatment – whether traditional or otherwise – and we strongly suggest that clients work with a coordinated care team to help them achieve their physical, emotional, and spiritual goals.

The following is a list of benefits from LET:

- Reduces inflammation and edema thereby improving comfort and increasing range of motion
- Eliminates byproducts of chemical protocols, cellular waste, and other accumulated substances (hormones, proteins, etc.) from the interstitial space
- Enhances tissue circulation and oxygenation
- Encourages healthy function of the immune system
- Fosters a state of relaxation and wellbeing

In order to receive the highest benefit from your overall treatment plan, we strongly encourage you to discuss your choice of LET treatments with your healthcare practitioner. Important items to discuss include but are not limited to the following:

- Comfort and/or pain reduction
- Desired time for therapeutic agents (chemicals, biologics, herbs, etc.) to remain active in your system prior to clearing/eliminating through LET
- Tissue oxygenation/deprivation goals
- Anything else that *you* feel is a priority

If you would like our LET practitioner to contact your healthcare provider to discuss how LET can best support you and your treatment goals, please complete and sign the authorization below.

Authorization to disclose medical information:

I authorize the Lymphatic Enhancement therapist:____________________________________ to contact the following practitioner:____________________________________ at the following phone number:____________________________, or via the following fax or e-mail: ____, to discuss my health history and treatment plan as it pertains to LET.

Signature:______________________________________ Date: ______________________________