



**An Integrated Health Resource**

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**LYMPHATIC DRAINAGE THERAPY  
Health Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. What condition(s) are you looking for help with? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How long have you experiencing this? \_\_\_\_\_

3. What type of therapy(s), treatments, remedies, etc., have you used in the past for this?  
\_\_\_\_\_  
\_\_\_\_\_

4. Have you ever been diagnosed with venous insufficiency, lymph edema, congestive heart failure, cardiovascular disease, and pulmonary disease? If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Have you ever had endocarditis (infection in the lining of the heart), rheumatic fever or dental infections? \_\_\_\_\_  
\_\_\_\_\_

6. Have you ever used Phen Fen and been diagnosed with heart valve damage? \_\_\_\_\_  
\_\_\_\_\_

7. Are you currently or have you ever used street drugs, including marijuana, methamphetamines, ecstasy, cocaine, PCP/angel dust, etc? If yes, how long since your last use? \_\_\_\_\_  
\_\_\_\_\_

8. Have you ever used steroid hormones for sports, autoimmune deficiencies or allergies or asthma? \_\_\_\_\_  
\_\_\_\_\_

9. Are you currently using steroid hormones? \_\_\_\_\_

10. Have you ever had surgery? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Do you have a pacemaker? \_\_\_\_\_

12. Have you ever had a known chemical exposure (toxic waste, clean chemicals, furniture refinishing, pet grooming tick medicine, gardening pesticides, etc.)? \_\_\_\_\_  
\_\_\_\_\_

13. Have you ever used prescription medications for more than a few days? If yes, please explain: \_\_\_\_\_

14. Please list all prescriptions, vitamins, minerals, OTC medications, etc., you are currently using: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Have you ever smoked or do currently smoke? \_\_\_\_\_

16. For women: Are you menopausal, cycling, pregnant or hoping to become so? \_\_\_\_\_  
\_\_\_\_\_

17. For women: Do you have a history of fibrocystic breast or uterine or endometrial dysplasia? \_\_\_\_\_

18. Have you ever used birth control for contraception? \_\_\_\_\_

19. Do you eat any soy-based products or take soy-based supplements? \_\_\_\_\_  
\_\_\_\_\_

20. Describe your eating habits: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_