

# Lipedema Intake Form

(Please complete in addition to a complete health history)

## Personal Information

Name \_\_\_\_\_

DOB \_\_\_\_\_

■ Have you been formally diagnosed with lipedema?

Yes  No

■ Does someone else in your family have Lipedema?

Yes  No

■ Have you been evaluated by an expert?

Endocrinologist  Yes  No

Vascular Specialist  Yes  No

Nutritionist  Yes  No

Physical Therapy for functional improvement -  
(balance and movement)  Yes  No

Psychotherapist  Yes  No

Other  Yes  No

Tell me more: \_\_\_\_\_

■ What treatments have you tried in the past? How well did they work?

Tell me more: \_\_\_\_\_

■ Are you currently under medical supervision for lipedema, lymphedema or any other condition?

Yes  No

If yes, please tell me more: \_\_\_\_\_

■ Do you exercise regularly?  Yes  No

If yes, please tell me more: \_\_\_\_\_

■ Do you perform any repetitive movement in your work or at home?  Yes  No

If yes, please tell me more: \_\_\_\_\_

■ Do you sit for long periods at a work, home or while driving?  Yes  No

If yes, please tell me more: \_\_\_\_\_

■ Do you experience stress?  Yes  No

If yes, please tell me more: \_\_\_\_\_

■ Does your stress result in any of these symptoms?  
(circle all that apply)

muscle tension / anxiety / insomnia / irritability / other

■ Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

Yes  No

If yes, please tell me more: \_\_\_\_\_

■ Are you experiencing discomfort in your body?

Yes  No

If yes, please tell me more: \_\_\_\_\_

■ Do you suffer from chronic pain?  Yes  No

If yes, please tell me more: \_\_\_\_\_

■ Do you have areas of swelling and/or inflammation?  Yes  No

If yes, please tell me more: \_\_\_\_\_

■ Have you had a recent injury or surgery?  Yes  No

If yes, please tell me more: \_\_\_\_\_

■ Do you have any allergies?  Yes  No

If yes, please tell me more: \_\_\_\_\_

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- Do you have hypermobility?

If so, tell me more: \_\_\_\_\_

\_\_\_\_\_

- Do you have venous issues?

If so, tell me more: \_\_\_\_\_

\_\_\_\_\_

- What self care are you using for your lipedema?

(Circle all that apply)

Self-lymphatic massage

Self-massage (with roller or tool)

Stress reduction

Adequate sleep

Hobbies

Social Activities

Compression Garments

Exercise / Movement

Supplements

Mindfulness

Talk Therapy

- Are you currently experiencing: (circle all that apply)

GI Conditions: nausea / upset stomach diarrhea / constipation

Musculoskeletal: joint pain / muscular pain / headache / touch pressure sensitivity / decreased range of motion or function / joint replacement

Nervous System: burn / itch / tingle / prickle / numbness in arms, / hands / legs / feet / memory problems

Skin: skin infection / dry skin / fragile skin / skin irritation / skin reaction

Circulatory/Lymphatic: edema / easy bruising / sensitivity to cold/heat / lymphedema / heart condition / high blood pressure

## General: fatigue depression anxiety allergies

- What makes your lipedema symptoms better?

\_\_\_\_\_

- What makes your lipedema symptoms worse?

\_\_\_\_\_

- How have your symptoms changed over time?

\_\_\_\_\_

- When during the day or week is your pain worse?

When is it better?

\_\_\_\_\_

- What type of massage are you seeking? (circle all that apply)

Relaxation Massage / Lymphatic Massage / Deeper Techniques

- Have you received a professional massage before?

Yes  No

If yes, how often do you receive massage therapy?

\_\_\_\_\_

- Do you have any difficulty lying on your front, back, or side?  Yes  No

- What are your goals for this treatment session?

\_\_\_\_\_

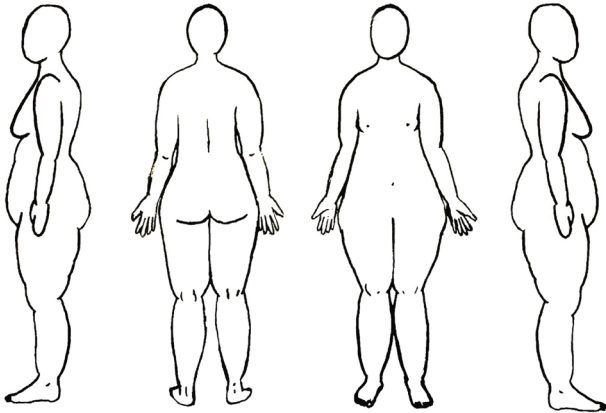
- Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?  Yes  No

If yes, please tell me more: \_\_\_\_\_

\_\_\_\_\_

# Lipedema Intake Form

Please circle any areas you would like to concentrate on during our session



■ Where is the lipedema fat on your body?

\_\_\_\_\_

■ Please share any tips you have for living with lipedema and weight stigma.

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If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client: \_\_\_\_\_

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