Manual Lymphatic Drainage Therapy Intake Form

Today's Date: _____

Name: _____ Birth Date: _____

Address: _____

Phone: _____ Email: _____

In Case of Emergency: _____ Phone: _____

Name of Primary Care Physician: _____

Referred By: _____

For what reason are you seeking Manual Lymphatic Drainage? (Note: if there is a question you do not feel comfortable answering, you can leave it blank and we will go over it in the visit if necessary.)

CHECK ONE: _____ Therapeutic _____ Medical Issue
If you are here for a medical issue, when did the problem start?_____

Please describe your problem including where it is and its severity. _____

_____

Are you currently undergoing cancer treatments: _____Yes ____ No

If yes, date of last chemotherapy treatment: _____

Personal Past History of Illnesses:

Illnesses	Yes	No
Arthritis / Joint Problems		
Asthma		
Aneurysm		
Back Problems		
Bowel Problems		
Broken Bones		
Cancer (any kind)		
Circulation Problems		
Collagen Vascular Disease (Lupus)		
Convulsions / Epilepsy		
Deep Vein Thrombosis		
Depression / Anxiety Seizures		
Diabetes		

Illnesses	Yes	No
Heart Attack / Problems		
High Blood Pressure		
HIV / AIDS		
Kidney Infections / Stones		
Liver Disease		
Migraine Headaches		
Osteoporosis		
Pneumonia / Lung disease		
Rheumatic Fever		
Stroke		
Thyroid Disease		
Tuberculosis		
Other:		

Current medications (Including hormones, vitamins, herbs, nonprescription medications):

_____

Surgical History:
Operation: _____Hospital: _____ Date: _____

General Reason for Surgery: _____

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Review of Current Symptoms:

Symptom	Notes
Acute Deep Vein Thrombosis	
Allergic	
Arthritis	
Cardiovascular	
Chest pain or pressure	
Congestive Heart Failure	
Currently Menstruating	
Currently Pregnant	
Cuts that do not stop bleeding	
Dizziness	
Ear fullness	
Earaches	
Ears, Nose, Throat	
Enlarged lymph nodes (glands)	
Fatigue	
Female Reproductive	
Fever	
Fibrocystic Breast Disease	
Frequent bruises	
Gastrointestinal	
Hematologic / Lymphatic	
Itchy eyes Runny nose	
Kidney Stones	
Lumps	
Lymph Nodes Removed	
Major Scars	
Moles	
Musculoskeletal	
Nausea Abdominal pain	
Neurologic	
Osteoporosis	
Palpitations	
Rash	
Recent Sinus Surgery	
Recent Surgery	
Ringing in ears	
Seizures	
Sinus congestion or problems	
Skin	
Swelling of legs	
Urinary Tract Infection	
Varicose veins	
Weight gain	
Other:	
Other:	

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Any information (medical or other) not specified in this intake form that you feel is important for the practitioner to know:

_____
_____
_____
_____
_____

I understand that the Manual Lymphatic Drainage I receive is provided for the basic purpose of improving the flow of my lymphatic system and also for relaxation. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage or bodywork 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 of which I am aware. I understand that massage/bodywork practitioners 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/ bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

*Please Note: Manual Lymphatic Drainage (MLD) is a very powerful modality and certain medical conditions are contraindicated and determine if and when you can receive a session. After the consultation and review of the information you have provided on this form, it will be determined if MLD should be administered to you today. Some conditions will require a note from your doctor before proceeding. Please understand this is for your safety and well-being. Your health is important to me.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of Minor:

By my signature below, I hereby authorize Lymphatic USA, to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____Date _____