MANUAL LYMPHATIC DRAINAGE INTAKE FORM

Today's Date: _____

Name: _____ Birth Date: _____

Address: _____

Phone: _____ Email: _____

In Case of Emergency: _____ Phone: _____

Primary Care Physician and Clinic: _____

For what reason are you seeking Manual Lymphatic Drainage?
___Medical reason ___Relaxation

If you are here for a medical issue, when did the problem start?

_____

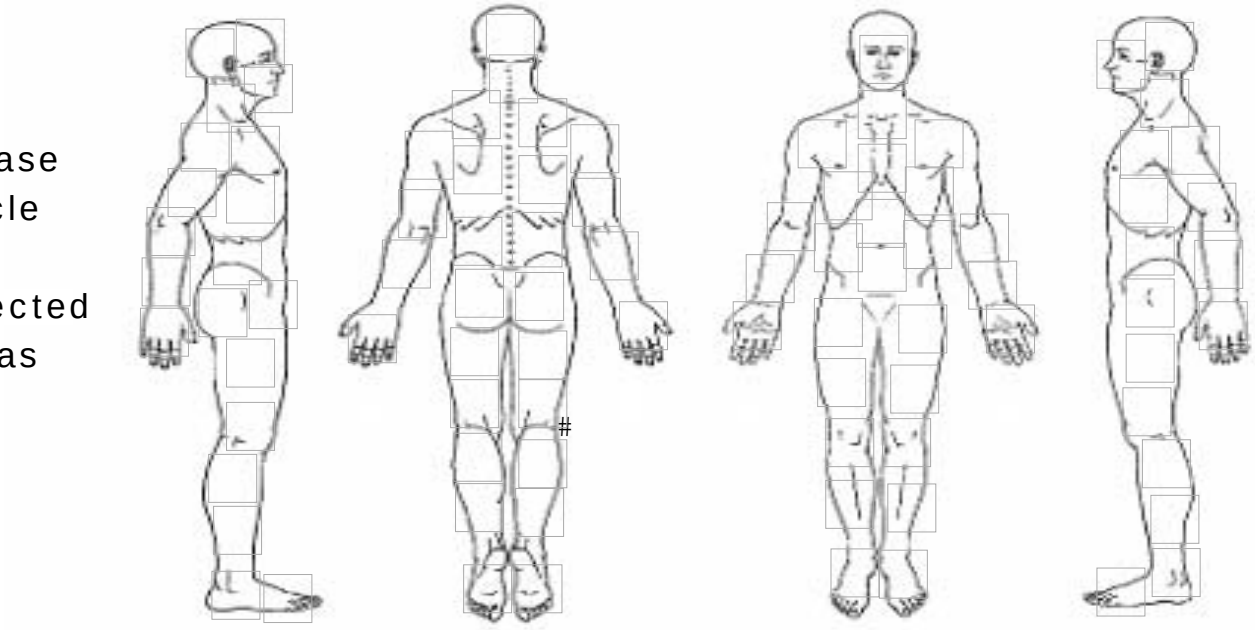
Please describe your problem including where it is and its severity.

_____

_____

_____

Please circle all affected areas



Please mark all current and previous conditions that apply

General		Female Reproductive	
Fever Since when? Under treatment?	☐	Currently pregnant	☐
Cancer Present___ past____ Where?_____ Last treatment date:_____ Undergoing cancer treatment_____ Last chemotherapy session_____ Last radio session_____ Additional info may be needed		Currently menstruating	☐
		Fibrocystic breast disease	☐
Arteriosclerosis	☐	IUD	☐
Carotid sinus issues	☐	Other:	☐
Hyperthyroidism	☐	**Musculoskeletal**	
Liver Cirrhosis	☐	Osteoporosis	☐
Other:		Osteoarthritis	☐
Ears, Nose, Throat		Hernia	☐
Ringing in ears	☐	Rheumatoid arthritis	☐
Sinus problems	☐	Other:	☐
Earaches	☐	**Skin**	
Other:		Cellulitis-acute___ not acute____ Treated? Yes___ No___ When?_____ Under treatment?	☐
Cardiovascular		Rash	☐
Congestive heart failure Treated? Yes___ No___ When?_____ Under treatment?	☐	Major scars	☐
Acute deep vein thrombosis Treated? Yes___ No___ When?_____ Under treatment?	☐	Lumps	☐
Blood clots? Treated? Yes___ No___ When?_____ Under treatment?	☐	Other:	☐
Chest pain or pressure	☐		
Swelling of legs	☐	**Hematologic/ Lymphatic**	
Palpitations	☐	Cuts that do not stop bleeding	☐
Varicose veins	☐	Enlarged lymph nodes (glands)	☐

Please mark all current and previous conditions that apply

Dizziness		Lymph nodes removed	
Heart attack		Frequent bruising	
High/Low blood pressure		HIV/AIDS:	
Aneurysm		Other:	
Cardiac arrhythmia		Neurological	
Other:		Strokes	
Gastro-Intestinal		Seizures	
Crohn's disease		Other:	
Abdominal pain		Allergies	
Surgical implant (mesh or other)		Ear fullness	
GI inflammation		Sinus congestion	
Diverticulitis/Diverticulosis:		Recent sinus surgery	
Other		Other:	
Urinary		Emotional	
Kidney failure Dialysis? Under treatment?		Stress	
Kidney disease? What? When? Under treatment?		Anxiety	
Kidney stones		Difficulty sleeping	
Urinary tract infection		Depression	
Dialysis		Other:	
Other:			

Please list all surgeries (including Cesarean section).

Surgery	Date	City

Please list all medications (including vitamins, hormones, and herbs) and reason for prescription.

Medication	Reason

Is there is anything else that we should know about you or your needs before the session?

_____

_____

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.

Client Name: _____

Signature _____ Date _____