Manual Lymphatic Drainage Intake Form

Name: ____Today's Date: __________DOB: ________

Address: ____

Phone: ______________________________ Email: ____

In Case of Emergency: ______________________________ Phone: _______________________________

Name of Primary Care Physician: ____

Why are you seeking Manual Lymphatic Drainage? ____Medical reason ____Relaxation _____Detox

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

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Describe your problem including where it is and its severity.

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Please list all surgeries (including C- section).

Surgery	Date	Hospital / Surgeon

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

General		Female Reproductive	
Fever		Currently pregnant	
Undergoing cancer treatment		Currently menstruating	
Last chemotherapy session		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	
Cardiovascular		Rash	
Chest pain or pressure		Major scars	
Swelling of legs		Lumps	
Palpitations		Other:	
Varicose veins		Hematologic/ Lymphatic	
Dizziness		Cuts that do not stop bleeding	
Acute deep vein thrombosis		Enlarged lymph nodes (glands)	
Congestive heart failure		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		Stress	
Kidney stones		Anxiety	
Urinary tract infection		Difficulty sleeping	
Dialysis		Depression	
Other:		Other:	

Is there is anything else that your MLD therapist should know about you or your needs before the session?
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I understand that the Manual Lymphatic Drainage I receive is provided to improve the flow of my lymphatic system and for relaxation. If I experience any discomfort, I will inform my therapist so the pressure may be adjusted. Massage or bodywork should not be a substitute for medical examination, diagnosis, or treatment and I should see a qualified medical specialist for any mental or physical ailment I am aware of. I understand that massage therapists are not qualified to 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.
I affirm that I have stated all my known medical conditions. & agree to keep my therapist updated if any changes occur and understand there shall be no liability on the therapist's part if 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 , it will be determined if MLD should be administered to you today. Some conditions equire DR's approval for your safety and well-being.

Client Name: ____ Date __________________
Signature of Parent or Guardian(if applicable) ______________________________ Date_________