Manual Lymphatic Drainage Intake Form

Client's Name _____ **Cell #** _____

Email _____ **DOB** _____

Address _____

City _____ **ST** _____ **Zip** _____ **Occupation** _____

Emergency Contact _____ **Phone #** _____

Relationship to Client _____ **Referred By** _____

Snowbird ☐ Visitor ☐ Full Time ☐

Have you ever received Manual Lymphatic Drainage (MLD)? YES NO If so, when? _____

Have you received other types of bodywork? (For example, swedish or deep tissue massage)

_____ How long ago? _____

What are your goals for this session? _____

_____

For Clients with History of Cancer
(If not applicable to you, please skip to Page 2)

What was your diagnosis? Type and Stage _____

Are you in remission? YES NO Date of last treatment _____

Have you had chemotherapy? YES NO Radiation? YES NO

Adjuvant therapies? (For example, hormone or targeted therapy) _____

Have you had surgery? YES NO If so, where? _____

Have lymph nodes been removed? YES NO From where? _____

How many? _____ Do you notice swelling? YES NO

If you are currently receiving treatment, how often are you receiving it? _____

Do you have written permission from your healthcare provider to receive MLD? YES NO

For Clients Who Have Received Surgical Procedures
(If not applicable to you, please skip to Page 4)

Did your surgeon recommend post-surgical MLD? YES NO Date of surgery _____

If so, have you already received MLD after this surgery? YES NO # of sessions? _____

Are you experiencing pain, swelling, or bruising? (Circle all that apply) If so, where?

_____

Are you noticing thickening of the tissue (fibrosis)? YES NO Numbness? YES NO

Please mark ALL surgeries/procedures, or list if not seen below: _____

_____

Liposuction ___ 360 (around entire waist, abdomen, back) ___ Abdomen ___ Ankles ___ Arms ___ Back ___ Buttocks ___ Chin ___ Hips ___ Knees ___ Neck ___ Thighs ___ Waist and flanks	**Breast** ___ Areola ___ Augmentation ___ Fat transfer ___ Implants ___ Saline ___ Silicone ___ Breast Lift ___ Expanders ___ Implant Removal ___ Implant Revision ___ Reduction	**Body Lifts** ___ Abdominoplasty (Tummy Tuck) ___ Arm Lift ___ Body Contouring (Skin Removal ___ Buttock Enhancement (Brazilian Butt Lift - BBL) ___ Mommy Makeover (please ensure you check all procedures included) ___ Thigh Lift
Nonsurgical Fat Reduction ___ Cryolipolysis (CoolSculpt) ___ Injection lipolysis (Kybella) ___ Laser lipolysis (SculpSure) ___ Radiofrequency lipolysis (Vanquish)	**Face & Neck** ___ Brow Lift ___ Cheek Augmentation ___ Cheek Reduction ___ Chin ___ Ear ___ Eyelid ___ Face Lift ___ Facial Implants ___ Neck Lift ___ Rhinoplasty ___ Thread Lift	**Gender Affirmation Surgery** ___ Facial ___Transfeminine ___Transmasculine ___ Top ___Transfeminine ___Transmasculine ___ Bottom ___ Transfeminine ___ Transmasculine

Do you have issues with blood clots or clotting? YES NO
Were drains used following the procedure? YES NO Where? _____
Do you still have drains in place? YES NO How many? _____
Are you wearing compression garments? YES NO

Please provide details of your recent surgery - hospital/clinic, city and state, surgeon's name, any complications during the surgery or recovery process:

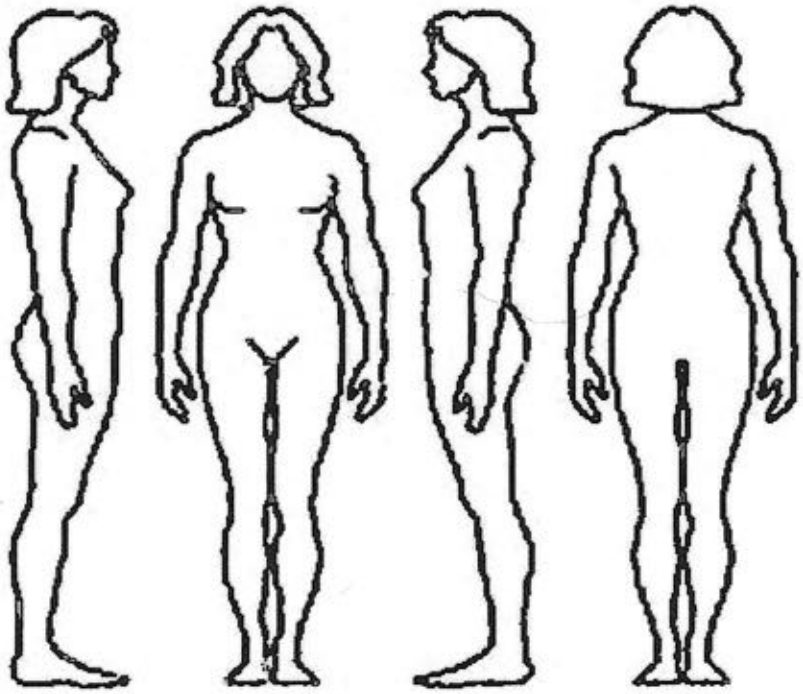
_____

_____

_____

_____

Please mark all areas that apply to your surgery:



Please list ALL medications and the reason for taking them. Please circle YES or NO if it is related to the surgery:

Medication	Reason	Related to Surgery?
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO

Health History

Please mark C for a current condition, P if a past condition and leave blank if not applicable. Please write in any additional symptoms or conditions not listed below:

_____

___Abdominal Pain	___Carpal Tunnel	___Gout	___Mold Illness	___SIBO
___ADD/ADHD	___Celiac Disease	___Headaches	___Multiple Sclerosis	___Sleep Disorders
___AIDS/HIV	___Chronic Fatigue	___Head Injury	___Muscle Pain	___Spasms
___Allergies	___Cold Sores	___Heart Attack	___Nausea	___STDs
___Aneurysm	___COPD	___Heart Palpitations	___Neck Pain	___Strains/ Sprains
___Ankle/Foot Pain	___Congestive Heart Failure	___Hepatitis	___Neuropathy	___Swelling of legs/arms (not related to surgery)
___Anorexia	___Constipation	___Hernia	___Open Wounds	___Tendonitis
___Anxiety	___Crohn's Disease	___HIV	___Osteoarthritis	___TOS
___Appendicitis	___Depression	___Insomnia	___Osteoporosis	___Thyroid Issues
___Arm Pain	___Diabetes	___IBS	___Pinched Nerve	___Tonsilitis
___Arthritis	___Diverticulitis	___IUD	___Pneumonia	___Tumors/ Growths
___Asthma	___Dizziness	___Jaw Pain	___Polio	___TMJ
___Auto Accident	___Earaches	___Joint Pain	___Psoriasis	___Ulcerative Colitis
___Autoimmune Disorder	___Ear Tubes	___Keloids	___Psychiatric Care	___Ulcers
___Back Pain	___Edema	___Kidney Stones	___Radiation	___Upper Back Pain
Blood Pressure	___Emphysema	___Leg Pain	___Rash	___UTI
___High	___Endometriosis	___Low Back Pain	___Rheumatoid Arthritis	___Varicose Veins
___Low	___Epilepsy	___Lyme's Disease	___Sciatica	
___Blood Clots	___Eye Strain/Pain	Lymph Nodes	___Seizures	
___Blood Thinner	___Fainting	___Enlarged	___Scoliosis	
___Broken/Fractured Bones	___Fibromyalgia	___Removed	___Shoulder Pain	
___Bronchitis	___Foot Pain	___MASA	___Sinus Issues	
___Bruises Easily	___Gas/bloating	___Major Scars		
___Bursitis		___Mid Back Pain		
___Cancer		___Migraine Headache		

Prior Surgeries and Treatments (include approximate year):

_____

_____

_____

_____

Please describe any history of the following (include approximate year):

Falls or Injuries:

_____

_____

Auto Accidents:

_____

_____

Pregnancies (Number of times, type of birth):

_____

I understand that the Manual Lymphatic Drainage (MLD) I receive is provided for the basic purpose of lymphatic drainage and movement. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the treatment, pressure and/or strokes may be adjusted to my level of comfort. I further understand that MLD should not be construed as a substitute for medical examination, diagnosis, or treatment and that I see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that MLD certified 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 MLD 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

CANCELLATION POLICY: For appointments canceled within 12 hours of session time, the full session fee will be charged. Any clients with a no show or late cancellation (within 12 hours) of an appointment will be required to put a credit card on file before making another appointment. I attest to have read this policy and agree to the cancellation terms.

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date