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	**Breast**	**Body Lifts**
____ 360 (around entire waist, abdomen, back) ____ Abdomen ____ Ankles ____ Arms ____ Back ____ Buttocks ____ Chin ____ Hips ____ Knees ____ Neck ____ Thighs ____ Waist and flanks	____ Areola ____ Augmentation ____ Fat transfer ____ Implants ____ Saline ____ Silicone ____ Breast Lift ____ Expanders ____ Implant Removal ____ Implant Revision ____ Reduction	____ 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:

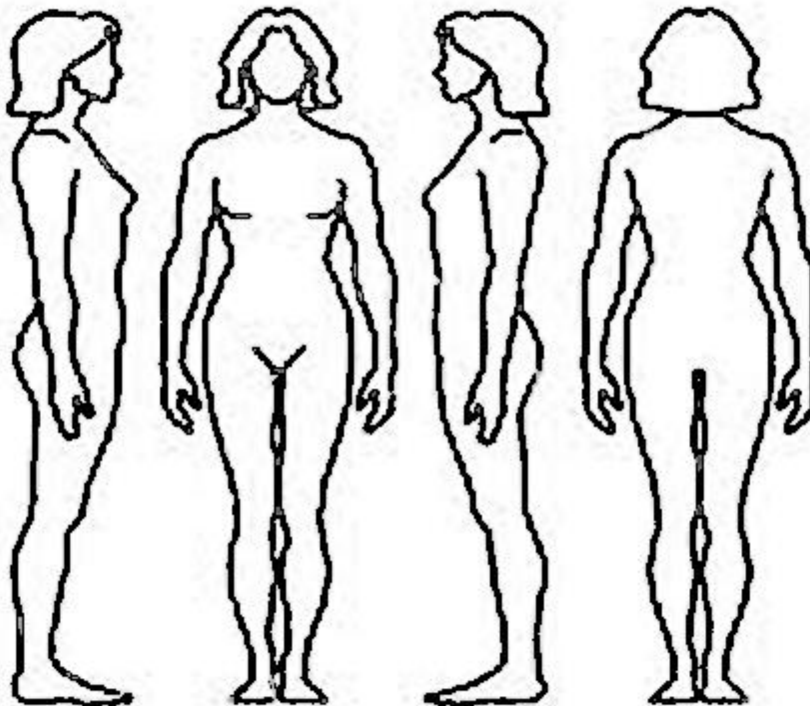
____

____

____

____

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 ____ADD/ADHD ____AIDS/HIV ____Allergies ____Aneurysm ____Ankle/Foot Pain ____Anorexia ____Anxiety ____Appendicitis ____Arm Pain ____Arthritis ____Asthma ____Auto Accident ____Autoimmune Disorder ____Back Pain Blood Pressure ____High ____Low ____Blood Clots ____Blood Thinner ____Broken/Fractured Bones ____Bronchitis ____Bruises Easily ____Bursitis ____Cancer	____Carpal Tunnel ____Celiac Disease ____Chronic Fatigue ____Cold Sores ____COPD ____Congestive Heart Failure ____Constipation ____Crohn's Disease ____Depression ____Diabetes ____Diverticulitis ____Dizziness ____Earaches ____Ear Tubes ____Edema ____Emphysema ____Endometriosis ____Epilepsy ____Eye Strain/Pain ____Fainting ____Fibromyalgia ____Foot Pain ____Gas/bloating	____Gout ____Headaches ____Head Injury ____Heart Attack ____Heart Palpitations ____Hepatitis ____Hernia ____HIV ____Insomnia ____IBS ____IUD ____Jaw Pain ____Joint Pain ____Keloids ____Kidney Stones ____Leg Pain ____Low Back Pain ____Lyme's Disease Lymph Nodes ____Enlarged ____Removed ____MASA ____Major Scars ____Mid Back Pain ____Migraine Headache	____Mold Illness ____Multiple Sclerosis ____Muscle Pain ____Nausea ____Neck Pain ____Neuropathy ____Open Wounds ____Osteoarthritis ____Osteoporosis ____Pinched Nerve ____Pneumonia ____Polio ____Psoriasis ____Psychiatric Care ____Radiation ____Rash ____Rheumatoid Arthritis ____Sciatica ____Seizures ____Scoliosis ____Shoulder Pain ____Sinus Issues	____SIBO ____Sleep Disorders ____Spasms ____STDs ____Strains/ Sprains ____Swelling of legs/arms (not related to surgery) ____Tendonitis ____TOS ____Thyroid Issues ____Tonsilitis ____Tumors/ Growths ____TMJ ____Ulcerative Colitis ____Ulcers ____Upper Back Pain ____UTI ____Varicose Veins

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