Massage Therapy Connections
Promoting Wellness • Relieving Pain

Manual Lymphatic Drainage Intake Form

Client's Name _____

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 <u>this</u> 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	**Face & Neck**	**Gender Affirmation Surgery**
___ Cryolipolysis (CoolSculpt) ___ Injection lipolysis (Kybella) ___ Laser lipolysis (SculpSure) ___ Radiofrequency lipolysis (Vanquish)	___ Brow Lift ___ Cheek Augmentation ___ Cheek Reduction ___ Chin ___ Ear ___ Eyelid ___ Face Lift ___ Facial Implants ___ Neck Lift ___ Rhinoplasty ___ Thread Lift	___ 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:

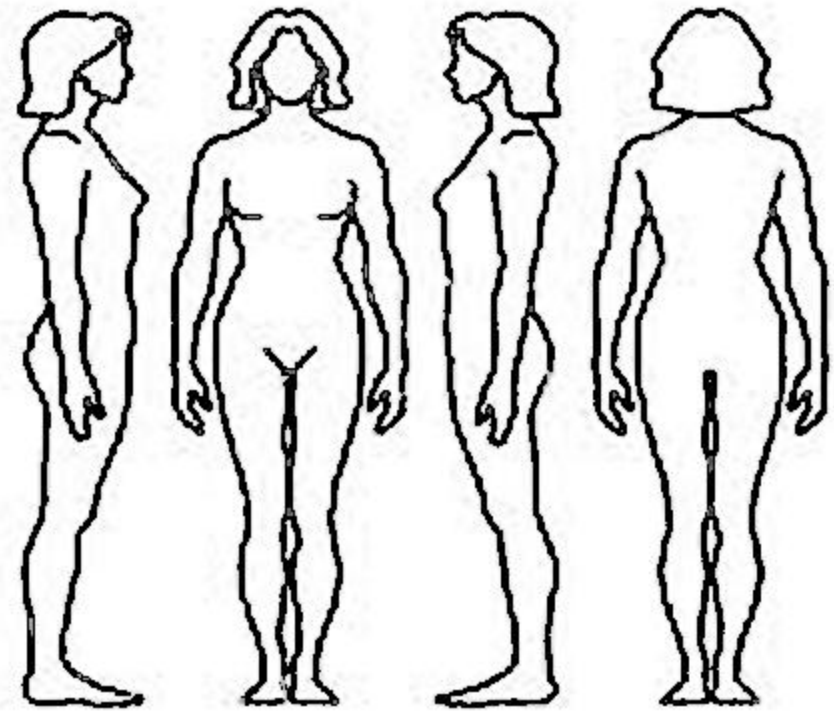
_____

_____

_____

_____

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