Lymphatic Massage Intake Form

Name:____Today's Date:_________
DOB: __/__/__
Address:____
Phone:__________________________Email:________________________________

Emergency Contact: Name____________________Phone:_________________
Relationship to patient:________________Referred by:__________________________

Personal Health History: **Please write down past or current symptoms for each category**

Abdominal pain	High blood pressure
Allergies	HIV/AIDS
Arthritis	Infection
Aneurysm	Kidney infections/stones
Autoimmune disorder	Liver Disease
Bowel problems	Low Blood pressure
Blood clots	Lung Disease
Broken bones	Migraine Headaches
Bruise Easily	Major organ failure
Cancer:	Major scars
Cardiovascular problem:	Musculoskeletal
Chronic Bronchitis	Nausea
Chronic Constipation	Neurologic Issues
Chronic Ear infections	Neuropathy
Congestive Heart Failure	Pneumonia
Clotting	Pregnancy
Deep vein thrombosis	Sinus congestion or problems
Depression/Anxiety	Skin issues
Diabetes	Stroke
Enlarged lymph nodes	Surgery
Fatigue	Swelling
fever	Tinnitus
Fibrocystic Breast	Thyroid Disorder/disease
Gastrointestinal Issues	Transient Ischemic Attack
Heart Attack	Weight gain
Head Injury/Concussion	Hematologic/Lymphatic issues

What is the reason you are seeking lymphatic massage today? ______________________________

Cancer Clients:

Are you currently undergoing cancer treatments? _________________

If yes, do you have written permission from your treatment team, to receive Manual Lymphatic Drainage, at this time?____ If no, what was the date of your last treatment?____

For Prenatal Clients:

Are you still experiencing morning sickness? __________________________________
Have you been told you are a high risk pregnancy?____________ If Yes, Do you have written permission from your Obstetrician to receive Manual lymph drainage at this time?____________

For Medical Referral Clients:

Do you give your therapist permission to consult with your referring provider your protected health information for the purpose of this visit? YES or NO

Medications currently taking:
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Please provide any other information, medical or otherwise, not specified in this intake form that you feel is important for the therapist to know:_________________________

**Please note: Manual Lymphatic Drainage (MLD) aka Lymphatic Massage, is a very powerful modality, and certain medical conditions are contraindicated and determine when you can receive a session. After 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, or consultation between your referring provider and lymphatic therapist, before proceeding. Please understand this is for your safety and well-being. I understand that manual lymphatic drainage should not be considered a substitute for medical examination, diagnosis, or treatment, and I should see a physician, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that lymphatic therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the sessions should be construed as such.*

Manual lymphatic drainage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly and to the best of my knowledge. 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.

Client Signature____Date:_____________________
Therapist Signature: _____________________________________ Date: ____________________