Lymph in Motion by Criselda White

Client Intake Form - Manual Lymphatic Drainage

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Therapist: Criselda White, LMT, CLT/CDT, CMLDT, MTI

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Client Information

Full Name

_____

Date of Birth

_____

Phone Number

_____

Email Address

_____

Home Address

_____

Emergency Contact (Name & Phone)

_____

Medical History & Current Health

[ ] Recent Surgery (within 6 months)

[ ] Heart Conditions / Cardiovascular Disease

[ ] Active or History of Cancer

[ ] Diabetes

[ ] Blood Clots or Deep Vein Thrombosis (DVT)

[ ] Kidney Disease or Dysfunction

[ ] Immune or Lymphatic Disorders

[ ] Infections, Fever, or Flu-like Symptoms

[ ] Open Wounds or Skin Infections

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[ ] Uncontrolled High Blood Pressure

[ ] Varicose Veins

[ ] Other (please specify)

Are you currently under a physician's care? [ ] Yes [ ] No

_____

If yes, provide physician's name and contact:

_____

Are you currently taking any medications? [ ] Yes [ ] No

_____

If yes, please list:

_____

Do you have any known allergies? [ ] Yes [ ] No

_____

If yes, please list:

_____

Contraindications for MLD

[ ] Acute infections

[ ] Congestive heart failure or uncontrolled cardiovascular conditions

[ ] Active cancer (without physicians clearance)

[ ] Kidney failure or advanced kidney disease

[ ] Deep Vein Thrombosis (DVT)

[ ] Uncontrolled hypertension

[ ] Post-operative clients without sufficient recovery time

[ ] Fever or systemic illness

[ ] Severe, untreated lymphedema

Indications for MLD

[ ] Post-surgical swelling (with physician approval)

[ ] Lymphedema (mild to moderate stages)

[ ] General swelling or fluid retention

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[ ] Immune system support

[ ] Detoxification and body rebalancing

Client Acknowledgment & Consent

I certify that the above information is accurate and complete to the best of my knowledge.
I understand that Manual Lymphatic Drainage (MLD) is a gentle, non-invasive therapy and may not be appropriate for all conditions. My therapist may consult with my physician or request a medical release before proceeding if necessary.
I acknowledge that failure to disclose health conditions or medications may pose health risks and may lead to refusal of treatment. I consent to treatment under these conditions and understand that MLD does not replace medical care.

Client Signature

_____

Date

_____

Therapist Signature

_____

Date

_____