Manual Lymphatic Drainage Intake Form

Journey Therapeutic Massage

Today's Date: _____

Name: _____ Birth Date: _____

Address: _____

Phone: _____ Email: _____

In Case of Emergency: _____ Phone: _____

Name of Primary Care Physician and Clinic: _____

For what reason are you seeking Manual Lymphatic Drainage? ____Medical reason ____Relaxation

If you are here for a medical issue, when did the problem start?

_____

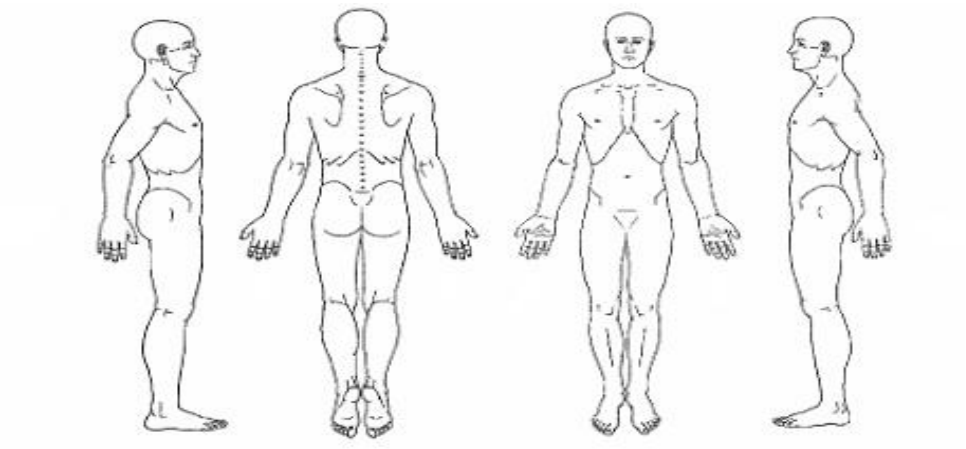
Please describe your problem including where it is and its severity.

_____

_____

_____

Please circle all affected areas.



In order to create the most beneficial session, please mark all current and previous conditions that apply.

General		Female Reproductive	
Fever		Currently pregnant	
Undergoing cancer treatment		Currently menstruating	
Last chemotherapy session		Fibrocystic breast disease	
Arteriosclerosis		IUD	
Carotid sinus issues		Other:	
Hyperthyroidism		Musculoskeletal	
Liver Cirrhosis		Osteoporosis	
Other:		Osteoarthritis	
Ears, Nose, Throat		Hernia	
Ringing in ears		Rheumatoid arthritis	
Sinus problems		Other:	
Earaches		Skin	
Other:		Cellulitis	
Cardiovascular		Rash	
Chest pain or pressure		Major scars	
Swelling of legs		Lumps	
Palpitations		Other:	
Varicose veins		Hematologic/ Lymphatic	
Dizziness		Cuts that do not stop bleeding	
Acute deep vein thrombosis		Enlarged lymph nodes (glands)	
Congestive heart failure		Lymph nodes removed	
Heart attack		Frequent bruising	
High/Low blood pressure		HIV/AIDS:	
Aneurysm		Other:	
Cardiac arrhythmia		Neurological	
Other:		Strokes	
Gastro-Intestinal		Seizures	
Crohn’s disease		Other:	
Abdominal pain		Allergies	
Surgical implant(mesh or other)		Ear fullness	
GI inflammation		Sinus congestion	
Diverticulitis/Diverticulosis:		Recent sinus surgery	
Other		Other:	
Urinary		Emotional	
Kidney failure		Stress	
Kidney stones		Anxiety	
Urinary tract infection		Difficulty sleeping	
Dialysis		Depression	
Other:		Other:	

Please list all surgeries (including Cesarean section).

Surgery	Date	Hospital and Surgeon

Please list all medications (including vitamins, hormones, and herbs) and reason for prescription.

Medication	Reason

Is there is anything else that your MLD therapist should know about you or your needs before the session?

_____

_____

I understand that the Manual Lymphatic Drainage I receive is provided for the basic purpose of improving the flow of my lymphatic system and also for relaxation. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork 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 massage/ bodywork 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 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.

*Please Note: Manual Lymphatic Drainage (MLD) is a very powerful modality and certain medical conditions are contraindicated and determine if and when you can receive a session. After the 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 before proceeding. Please understand this is for your safety and well-being.

Client Name: _____ Date _____
Practitioner Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize the administration of Manual Lymphatic Drainage techniques to my child or dependent as the therapist deems necessary.
Signature of Parent or Guardian _____ Date _____