Health History

MLD CLINIC
LYMPHATIC MASSAGE THERAPY

About you

Name _____ DOB (d/m/y) _____

Cell _____ Home _____ Gender _____

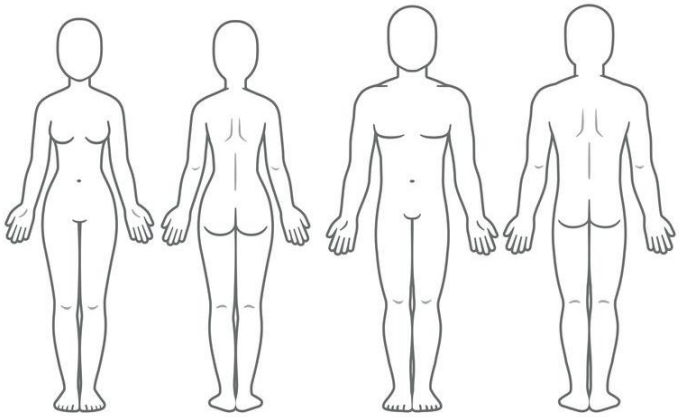
Address _____

Email _____

Your GPs name and location _____

Name and location of referrer _____

Where are you having swelling and/or pain? (circle the areas)



Your current status

Are you seeking therapy because of a car accident?	Y	N
Have you had dental work in the last 7 days?	Y	N
Have you had a vaccination in the past 7 days?	Y	N
Are you currently on antibiotics?	Y	N
Are you having an allergic reaction today?	Y	N
Have you every had tuberculosis (TB)?	Y	N
Are you pregnant?	Y	N

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Current and past health conditions (check those that apply)

high blood pressure	lymphedema	bone fracture
how blood pressure	lipedema	severe sprain
stroke	blood clots/DVT	torn ligament
heart attack	varicose veins	joint injury
asthma	cancer	concussion
COPD	epilepsy	colitis or ileitis
HIV/AIDS	Parkinson's	Crohn's
bronchitis	nerve pain	celiac
hepatitis	MS	chronic constipation

Any other conditions? _____

List any surgeries you've had _____

Current medications (please note)

_____

_____

Consent to treatment & cancellation policy acknowledgement

I consent to treatment from the MLD Clinic and understand I can withdraw my consent at any time. Signature _____ Date _____

I acknowledge the MLD Clinic's 48-hour cancellation policy and agree to pay the full fee for my session should I miss any appointment or cancel late.

Initials _____ Date _____