Manual Lymphatic Drainage Intake Form

(CONFIDENTIAL INFORMATION)

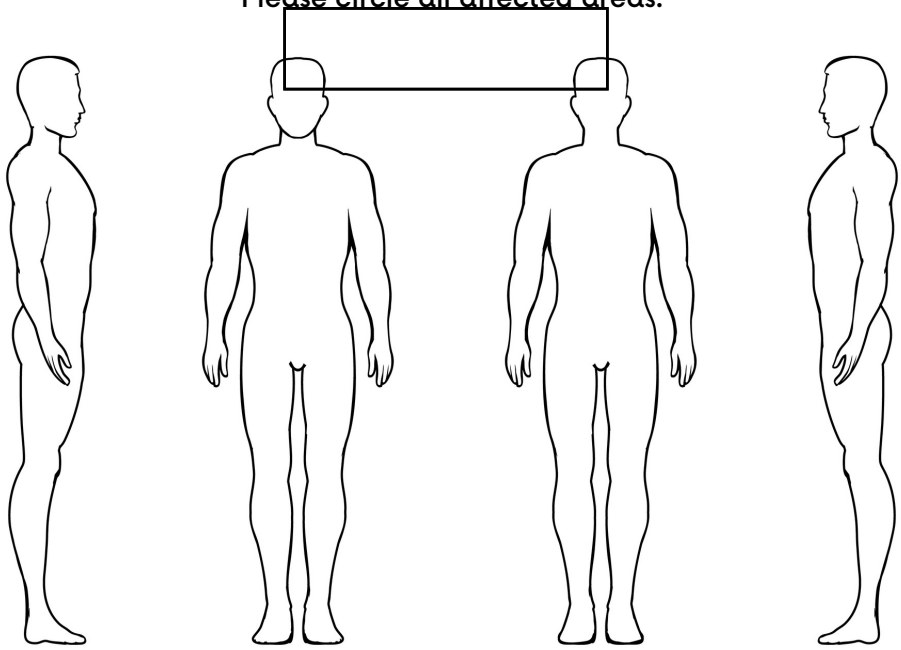
Name:	**Date:**
Occupation:	**Date of Birth**
Phone No.:	**Email:**
Address:	
Emergency Contact Name & Number:	
Name of Primary Care Physician and Clinic:	

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 chemotheraphy session		Fibrocystic health 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	
		Seizures	
		Other:	

Gastro-Intestinal		Allergies	
Crohn's disease		Ear fullness	
Abdominal pain		Sinus congestion	
Surgical implant (mesh or other)		Recent sinus surgery	
GI inflammation		Other:	
Diverticulitis/Diverticulosis:		**Emotional**	
Other:		Stress	
Urinary		Anxiety	
Kidney failure		Difficulty sleeping	
Kidney stones		Depression	
Urinary tract infection		Other:	
Dialysis			
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?

None

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: Ashley Solórzano Date:

Practitioner Signature: Date:

Consent to Treatment of Minor: By my signature below, I hereby authorize (Name of Technician), to administer Manual Lymphatic Drainage techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: Date:

Brazilian Manual Lymphatic Drainage Consent Form

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to, microablation, electrolysis, facial toning, body treatments, ionization, laser treatments, vein treatments, wood treatments, lymphatic drainage and various other beauty procedures is not an exact science and no specific guarantees can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to realize a difference.

I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results (you must follow the aftercare instructions), soreness, change in skin pigmentation and allergic reaction (please let us know if you' re allergic to anything I understand that even though precautions may be taken in my treatment, not all risks can be known in advance).

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability (Name of Facility) and the individual that provided my treatment, the insured, and any additional insureds, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may affect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

The client indicated below also agrees to forever hold harmless and release (Name of Facility) from any and all liability, claims, or demands of any kind or nature related to the transmission of any disease, condition or illness they may allege to have contracted or been exposed to as the result of any treatment, person, or visit at the insured's location.

Printed Name: Ashley Solórzano	**Signature**
Date:	

In consideration for treatment received, I hereby grant permission to (Name of Facility) to use any photographic treatment records for the purposes of clinical and statistical studies, advertising, or promotion without any additional compensation to me.

Printed Name:	**Signature**
Date:	