INTAKE FORM LYMPHATIC DRAINAGE (MLD)

All information is kept confidential and will become part of your personal file.in order to provide the best possible care and to insure optimum results from your sessions, the following information is essential and should be completed completely and accurately. If your intake is not completed accurately, thoroughly, and completely; we will not be able to perform your service.

Name (Please Print)_____
Date_____ Sex F M Birthdate:_____
Address_____
City_____ State_____ ZIP_____
E-Mail Address: (Please Print)_____
Home Phone (____)_____ Cell Phone (_____) _____
Place of Business _____Occupation _____
Referred by_____
Have you had Lymphatic Drainage before? YES NO
Emergency Contact: Name _____
Phone _____

1. What is your objective for this therapy?

_____
_____

2. Are you currently being treated for this condition by:
( ) Medical Doctor Name_____
Release Yes_____ No_____

3. Please list any present medications used and their purpose: (use back of form for additional space) Please include aspirin, ibuprofen, etc….
Med_____Purpose_____
Med_____Purpose _____

4. Have you ever been diagnosed with lymphedema or any other lymphatic condition(s)?
Explain:

_____
Where is the swelling located on the body?

_____
When did the swelling begin? Explain:

_____
Do you suffer from frequent swelling? Explain:

_____
Do you wear a compression garment? If so, what kind.

_____

5. Please check and explain any of the following that apply to you:
[ ] Surgeries & Dates_____
_____
[ ] Injuries_____

6. Do you exercise regularly? Y___N___ If yes, how often? _____
7,. Do you use dairy products? Y___N___ If yes, how much per day?_____

Lymphatic Drainage (MLD)

Please check any of the following conditions that apply:

( )Botox Injection	( )High Blood Pressure	( )Lipedema	( )Bursitis
( )Breast Modification	( )Steroid Inj	( )Low Blood Pressure	
( )Aneurysm	( )Phlebitis	( )Diabetes	
( )Cardiac Edema	( )Fibromyalgia	( )Pregnant	( )Hematoma
( )Bronchial Asthma	( )Stroke	( )Varicose Veins	
( )HIV/AIDS	( )TMJ	( )Carotid-Sinus Syn	
( )Renal Failure	( ) Survivor of abuse	( )Crohns	( )Leg Pain
( )Carotid Endarterectomy	( )Cancer	( ) Lymphedema	
( )Auto-immune	( )Constipation	( )Digestive Disorder	

Please understand that due to answering questions we do not diagnose or prescribe but offer information only to help you to cooperate with your doctor in your mutual quest of building optimum health. I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.

It is my choice to receive Lymphatic Drainage. I realize that the treatment is being given for the well-being of my body. I agree to communicate with my therapist any time I feel like my well being is being compromised. All communications shared by the client during the session will be held confidential and will not be shared with others. I understand that the therapist is a Certified Lymphatic Drainage Technique Therapist. I have stated all medical conditions that I am aware of and will update the therapist of any changes in my health in the future.

Name Printed _____

Date _____ Signature _____