MANUAL LYMPHATIC DRAINAGE INTAKE FORM

** Confidential **

Name: _____ Date: _____

Street Address: _____City/State: _____

Postal Code: _____ Telephone (day): _____ (evening): _____

Email Address: _____

Emergency Contact: _____

Weight: _____ Height: _____ Age: _____ Date of Birth: _____

Gender: _____ Occupation: _____ Hours worked per week: _____

Recreational Activities: _____

Frequency: _____ How did you hear about my facility?_____
Reason for seeking this treatment: _____

PERSONAL INFORMATION - HEALTH HISTORY

Headaches (migraine) _____ Headaches (sinus) _____Headaches (tension) _____ Allergies _____
Sinus infections (frequent) _____ Allergies _____ Frequent colds _____ Chronic cough _____
Pregnant currently _____ Shortness of breath _____Chronic chest congestion _____
Are you a smoker? _____ Packs per day. Lymphedema _____

Lymphedema diagnosis? Yes _____/No_____ Lymphedema since childhood? Yes _____/No_____ Swelling goes down at night? Yes _____/No_____ Lymphedema-related pain Yes _____/No_____ Related infection(s)? Yes _____/No_____ Lymphedema due to cancer? Yes _____/No_____ If yes, were lymph nodes removed? Yes _____/No_____ If yes, from what area of the body? _____
Radiation treatment received? Yes _____/No_____

Please indicate the conditions that apply: High blood pressure _____ Low blood pressure _____
Dizziness _____ Diagnosed heart disease _____ Varicose veins _____
Poor circulation _____ Phlebitis _____ Sensitive skin _____ Rashes (frequent) _____
Skin eruptions (frequent) _____ Bruise easily _____ Swollen ankles _____
Chronic Venous Insufficiency _____

Night pain _____ Sleep disturbed by pain _____ Rheumatoid Arthritis _____ Osteoarthritis _____
Back pain _____ Neck pain _____ Shoulder pain _____ Chronic constipation _____
Difficult digestion _____ Diabetes _____ Frequent urination _____ Night sweats _____

Lipedema Yes_____/No_____. Onset/How long? _____
Diagnosis date: _____

Family history? Yes_____/No_____ How many members of the family? _____

Please turn over and complete opposite side of form

Present status of cancer: _____
Oncologist and date of last visit: _____
Explanations, as needed: _____

_____

_____

_____

Do you wear a compression garment? Y_____/N_____. Where? _____

Any other doctor diagnosed conditions? Please specify:

Recent surgeries (within the last ten years) including date(s): _____

_____.

Current medications: _____

_____.

Your referring / primary care physician:

Name: _____ Telephone: _____

Address:_____

Other health care: Chiropractic _____ Physiotherapy ____ Naturopathic ____ Acupuncture _____ Osteopath _____
Other (specify) _____

Have you had previous massage therapy experience? Yes _____/No _____

Manual Lymph Drainage in the past? Yes _____/No _____

PLEASE READ CAREFULLY AND SIGN BELOW

All statements made on this form are true to the best of my knowledge. I understand that all personal information provided is confidential as governed by law except to facilitate treatment or diagnosis. All information given here is given only to assist the therapist in delivering appropriate, safe and beneficial massage therapy treatments. All treatments will be within the scope of practice of massage therapy as defined by Texas law.

I understand the nature and purpose of the treatment will be explained to me and that I have the right to stop or modify the treatment at any time, as does my Licensed Massage Therapist. I understand I have the right to ask questions at any time. I understand the benefits of massage therapy include increased circulation to the tissues and increased relaxation, among other effects, and I may feel temporary soreness post-treatment (24-48 hours) or a slight dizziness on rising from the table. I understand my therapist must obtain consent to treat areas of my body that I have not previously given verbal consent to have treated. I do consent to treatment; I also understand that verbal consent must be given before any treatment.

I understand that I am responsible for payment in full of all treatment and related fees immediately following each of my appointments by cash, check or credit card. I understand that 24-hours notice by telephone is required to reschedule any future appointment, or full charges will apply.

_____ _____
Client's Signature Date

_____ _____
Therapist's Signature Date