



LYMPHATIC MASSAGE CLIENT INTAKE FORM: Please complete and bring to appointment.

CONFIDENTIAL CLIENT INFORMATION

Today's Date: _____

Name: _____ Birth Date: _____

Address: _____

Phone: _____ Email: _____

In Case of Emergency: _____ Phone: _____

Name of Primary Care Physician: _____

Referred By: _____

For what reason are you seeking Manual Lymphatic Drainage? *if there is a question you do not feel comfortable answering, you can leave it blank and we will go over it in the visit if necessary **CHECK ONE** Therapeutic Medical Issue

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

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

Current medications
(Including hormones, vitamins, herbs, nonprescription medications)

Personal Past History of Illnesses

Major Illnesses	(circle one)		Major Illnesses	(circle one)	
Asthma	Yes	No	Collagen Vascular Disease (Lupus)	Yes	No
Pneumonia / Lung disease	Yes	No	Bowel Problems	Yes	No
Kidney Infections / Stones	Yes	No	Depression / Anxiety	Yes	No
Tuberculosis	Yes	No	Seizures / Convulsions / Epilepsy	Yes	No
HIV / AIDS	Yes	No	Migraine Headaches	Yes	No
Stroke	Yes	No	Diabetes	Yes	No
Heart Attack / Problems	Yes	No	Thyroid Disease	Yes	No
Aneurysm	Yes	No	Arthritis / Joint / Back Problems	Yes	No
High Blood Pressure	Yes	No	Osteoporosis	Yes	No
Circulation Problems	Yes	No	Broken Bones	Yes	No
Deep Vein Thrombosis	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Cancer (any kind)	Yes	No

Other

Surgical History:			
Operation	Date	Reason	Hospital

Review of Current Symptoms (Check all that apply)			
General		Female Reproductive	
Weight gain	<input type="checkbox"/>	Currently Pregnant	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Currently Menstruating	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	Fibrocystic Breast Disease	<input type="checkbox"/>
Recent Surgery	<input type="checkbox"/>	Musculoskeletal	
Undergoing Cancer Treatments	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
**	Date of last chemotherapy treatment:	Arthritis	<input type="checkbox"/>
Ears, Nose, Throat		Skin	
Ringing in ears	<input type="checkbox"/>	Rash	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	Moles	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	Major Scars	<input type="checkbox"/>
Cardiovascular		Lumps	<input type="checkbox"/>
Chest pain or pressure	<input type="checkbox"/>	Hematologic / Lymphatic	
Swelling of legs	<input type="checkbox"/>	Frequent bruises	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	Cuts that do not stop bleeding	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	Enlarged lymph nodes (glands)	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Lymph Nodes Removed	<input type="checkbox"/>
Acute Deep Vein Thrombosis	<input type="checkbox"/>	Neurologic	
Congestive Heart Failure	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
Other:	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Gastrointestinal		Allergic	
Nausea	<input type="checkbox"/>	Ear fullness	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	Itchy eyes	<input type="checkbox"/>
Urinary		Runny nose	<input type="checkbox"/>
Urinary Tract Infection	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	Recent Sinus Surgery	<input type="checkbox"/>

Any information (medical or other) not specified in this intake form that you feel is important for the practitioner to know:

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. Your health is important to me.

Client Signature _____ Date _____

Consent to Treatment of Minor:

By my signature below, I hereby authorize Martha Reamy, LMT, to administer massage, bodywork or manual lymphatic massage therapy to my child or dependent.

Signature of Parent or Guardian _____ Date _____

