Client Intake Form
Manual Lymphatic Drainage

Personal Information:

Client Name: ____ Date: ______/_____/________

Address: ____ City ________________ State __________ Zip: __________

Cell No.: ______________________ Age: _____ Birth Date: ____/____/_____ Sex at Birth: F____ M_____

Email Address: ______________________________________ Occupation: ______________________________________

I give my consent to contact me via: Email____ Phone____ Text_____

Whom may I thank for referring you? ____

Emergency Contact: _____________________________________ Phone: ____________________ Relationship: _____________

Have you ever received a Manual Lymphatic Drainage (MLD) massage? If so, when? ___________________________________

Other types of bodywork received? ____

What are your goals for this session? ____

For clients who have received plastic surgery procedures:

Did your surgeon recommend post surgical MLD? _____Yes _____No Suggested Number of Sessions:___________

Have you been cleared by your doctor to receive MLD? _____Yes _____No

If so, have you received MLD after surgery? _____ Yes _____No How many sessions?:__________________________

Are you in pain? _____Yes _____No Where: ____

Are you experiencing swelling or bruising? _____Yes _____No Where: ______________________________________

Which surgeries have you had, and when?

Liposuction
- __________ 360
- __________ Abdomen
- __________ Waist
- __________ Flanks
- __________ Arms
- __________ Hips
- __________ Buttocks
- __________ Back
- __________ Thighs
- __________ Neck/Chin
- __________ Other ________

Breast
- __________ Augmentation
- __________ Implant
- __________ Fat transfer
- __________ Lift
- __________ Removal
- __________ Implant Revision
- __________ Revision
- __________ Nipple
- __________ Removal
- __________ Other ____________

Body Lifts
- __________ Abdominoplasty
- __________ BBL
- __________ Arm Lift
- __________ Lower Body Lift
- __________ Mommy Makeover
- __________ Body Contouring
- __________ Hip Augmentation
- __________ Other __________________________
- __________ Other __________________________
- __________ Other __________________________

Neck and Face
- __________ Facelift
- __________ Rhinoplasty
- __________ Eyes/brow
- __________ Cheek Augmentatioi
- __________ Neck/Chin

Breast Reconstruction
- __________ Expanders
- __________ Areola
  - ______ Removal
  - ______ Reconstruction

Other
- ____
- ____
- ____
- ____
- ____

Were drains used following the procedures? ____ Yes _____No How many: _____ Date Removed:_________________

Are you noticing thickening or fibrosis _____ Yes _____ Nc If yes, where? ____________________________________'

Please provide all the details of your recent surgery (date, hospital/clinic, surgeon, surgeon's phone number):

____

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____

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____

Please list ALL medications, check if it's related to the surgery.

______________________________Yes _____ No ______ ______________________________Yes _____ No ______

______________________________Yes _____ No ______ ______________________________Yes _____ No ______

______________________________Yes _____ No ______ ______________________________Yes _____ No ______

______________________________Yes _____ No ______ ______________________________Yes _____ No ______

______________________________Yes _____ No ______ ______________________________Yes _____ No ______

______________________________Yes _____ No ______ ______________________________Yes _____ No ______

Please describe and provide dates:

Prior Surgeries ____

Auto Accidents ____

Falls/Injuries ____

Pregnancies ______________________________ Are you currently pregnant? _____ Yes _____No

DO YOU HAVE ANY ALLERGIES?: _____Yes _____No

Health History

Please circle alll conditions, mark C for a current condition, P if a past condition, and leave blank if not applicable

Abdominal Pain	Celiac Disease	Headaches	Migraine Headaches	Shoulder Issues
ADD/ADHD	Chronic Fatigue	Head Injury	Mold Illness	Sinus issues
AIDS/Hiv	Cold Sores	Hearing Issues	Multiple Sclerosis	SIBO
Allergies	COPD	Heart Attack	Muscle Pain	Sleep Disorders
Aneurysm	Congestive Heart Failure	Heart Palpitations	Nausea	Soft Tissue Issues
Ankle/Foot Pain	Constipation	Hepatitis	Neck Pain	Spasms
Anorexia	Crohn's Disease	Hernia	Night Sweats	STD's
Anxiety	COVID-19	Herniated Disk	Numbness/Tingling	Strains/Sprains
Appendicitis	Currently Pregnant	Herpes	Neuropathy	Stress
Arm Pain	Depression	HIV	Open Wounds	Stroke
Arthritis	Diabetes	Insomnia	Osteoporosis/arthritis	Surgical Implants

Health History (Continued): Please circle all that apply. Mark with C for current, P for past.

Asthma	Diverticulitis/osis	IBS	Pacemaker	Swelling of limbs
Athletes Foot	Dizziness	IUD	Phlebitis	Tendonitis
Auto Accident	Earaches	Jaw Pain	Pinched Nerve	TOS
Autoimmune Disorder	Ear Tubes	Joint Issues	Pneumonia	Thyroid Issues
Back Pain	Eczema	Kidney Issues	Polio	Tinnitus
Blood Pressure	Edema	Knee Pain	POTS	Tonsilitis
___ High ___ Low	Emphysema	Leg Pain	Psoriasis	Tuberculosis
Blood Clots	Endometriosis	Liver Issues	Psychiatric care	Tumors/Growths
Blood Thinner	Epilepsy	Low Back Pain	Radiation	TMJ
Broken Fractured Bone	Eye strain/pain	Lyme Disease	Rash	Ulcerative Colitis
Bronchitis	Fainting	Lymph Nodes	Respriratory Issues	Ulcers
Bruises easily	Fibromyalgia	Enlarged	Rheumatoid Arthritis	Upper back pain
Bursitis	Foot Pain	Removed	Sciatica	UTI
Cancer	Gas bloating	MASA	Skin Conditions	Varicose Veins
Carpal Tunnel	Gout	Major scars	Seizures	Vision Issues
		Mid Back Pain	Scoliosis	

Please explain conditions circled above: ____

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Is there anything else that your therapist should know before your session?

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I understand that the Manual Lymphatic Drainage I receive is provided for the basic purpose of improving the flow of my lymph 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 the qualifiied 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 peformed 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.

For Clients undergoing cancer treatments:

What is your diagnosis? ____

Are you currently undergoing cancer treatment? _____ Yes _____ No Radiation _____Yes _____No

Do you have written permission from your treatment team to receive MLD at this time? _____ Yes _____ No

What was the date of your last treatment? _______________________________

Do you give practitioner permission to contact your treatment team regarding receiving MLD at this time? ____Yes ____No

Were drains used in your procedure? _____Yes _____No If Yes, how many?___________________

Are surgical sites healed? _____Yes _____No

Date of last chemotherapy session? ______________________________

How many sessions have you had? _____ How many are recommended? _____

Please describe the full procedure and if there were any complications: ____

____

____

Please note: It is important that you complete this intake form in full. MLD is a very powerful modality and certain medical conditions are contraindicated and determine if or 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 well being.

Initial _____ Lymphatic Massage for Recovery, Inc. (LMfR), reserves the right to refuse, postpone or terminate treatment whenever we deem it is in the best interest of one or more of the parties.

Initial _____ I understand that massage is entirely therapeutic and non-sexual in nature. Inappropriate actions will forfieit the remainder of your session.

Initial _____ Release of Records/Permission to communicate concent: I hereby give LMfR consent to communicate with any and all practitioners involved in my treatment as they deem necessary.

Initial _____ Cancellation Policy. I agree to pay the full fee of the service missed if I do no give a 24-hr notice of cancellation or if I do not show up for an appointment

Initial _____ Minors: Parents must accompany any minor under 18 years of age to each and every appointment.

Minors name: ____________________________________ ____________ Age: ___________________

Client Signature: ____ Date: _______________________________

Practitioner Signature: ____ Date: _______________________________