Manual Lymphatic Drainage Intake Form

Personal Information	Emergency Contact:
Name: _____ DOB: _____	_____
Address: _____ City: _____ State: _____ Zip: _____	Phone: (_____) _____
Phone: (_____) _____ Email: _____	Referred by/How did you hear about us? _____
Occupation: _____	

For what reason are you seeking Manual Lymphatic Drainage?

Medical reason Relaxation

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

For cancer patients:

Are you currently undergoing cancer treatments? Yes No

If Yes, do you have written permission from your treatment team to receive MLD at this time? Yes No

If No, what was the date of your last treatment? _____

If you are here for a medical issue, please explain the problem:

_____

_____

_____

Have you been to a doctor? Yes No

If so, have you been diagnosed? _____

Have you been cleared by your doctor to receive MLD? Yes No

Have you received surgery? Yes No

If so, have you received MLD after surgery? Yes No How many sessions? _____

Please mark ALL surgeries/procedures

Common Cosmetic Surgeries		Common Surgeries	Other
☐ Liposuction:	☐ Breast	☐ Neck	
☐ 360	☐ Augmentation	☐ Shoulder	_____
☐ Abdomen	☐ Removal	☐ Knee	_____
☐ Waist/Flanks	☐ Lift	☐ Leg	_____
☐ Arms	☐ Abdominoplasty (Tummy Tuck)	☐ Hip	_____
☐ Hips	☐ Brazilian Butt Lift (BBL)	☐ Back	_____
☐ Thighs	☐ Hip Augmentation	☐ Foot	_____
☐ Back			_____
☐ Neck			_____

Surgery Date	Hospital / Clinic	Surgeon

Laurie D'Andrea
LMT, CLT/CDT,CCST

Call/Text: (702) 228-9038
laurie@lymphmassagevegas.com
www.lymphmassagevegas.com

In order to create the most beneficial session, please mark ALL current and previous conditions that apply

General	
Fever	
Undergoing cancer treatment	
Last chemotherapy session	
Arteriosclerosis	
Carotid sinus issues	
Hyperthyroidism	
Liver Cirrhosis	
Other:	
Ears, Nose, Throat	
Ringing in ears	
Sinus problems	
Earaches	
Other:	
Cardiovascular	
Chest pain or pressure	
Swelling of legs	
Palpitations	
Varicose veins	
Dizziness	
Acute deep vein thrombosis	
Congestive heart failure	
Heart attack	
High/Low blood pressure	
Aneurysm	
Cardiac arrhythmia	
Other:	

Gastro-Intestinal	
Crohn's disease	
Abdominal pain	
Surgical implant (mesh or other)	
GI inflammation	
Diverticulitis/ Diverticulosis:	
Other	
Urinary	
Kidney failure	
Kidney stones	
Urinary tract infection	
Dialysis	
Other:	
Female Reproductive	
Currently pregnant	
Currently menstruating	
Fibrocystic breast disease	
IUD	
Other:	
Musculoskeletal	
Osteoporosis	
Osteoarthritis	
Hernia	
Rheumatoid arthritis	
Other:	

Skin	
Cellulitis	
Rash	
Major scars	
Lumps	
Other:	
Hematologic/ Lymphatic	
Cuts that do not stop bleeding	
Enlarged lymph nodes (glands)	
Lymph nodes removed	
Frequent bruising	
HIV/AIDS:	
Other:	
Neurological	
Strokes	
Seizures	
Other:	
Allergies	
Ear fullness	
Sinus congestion	
Recent sinus surgery	
Other:	
Emotional	
Stress	
Anxiety	
Difficulty sleeping	
Depression	
Other:	

Everyday Lymphatics

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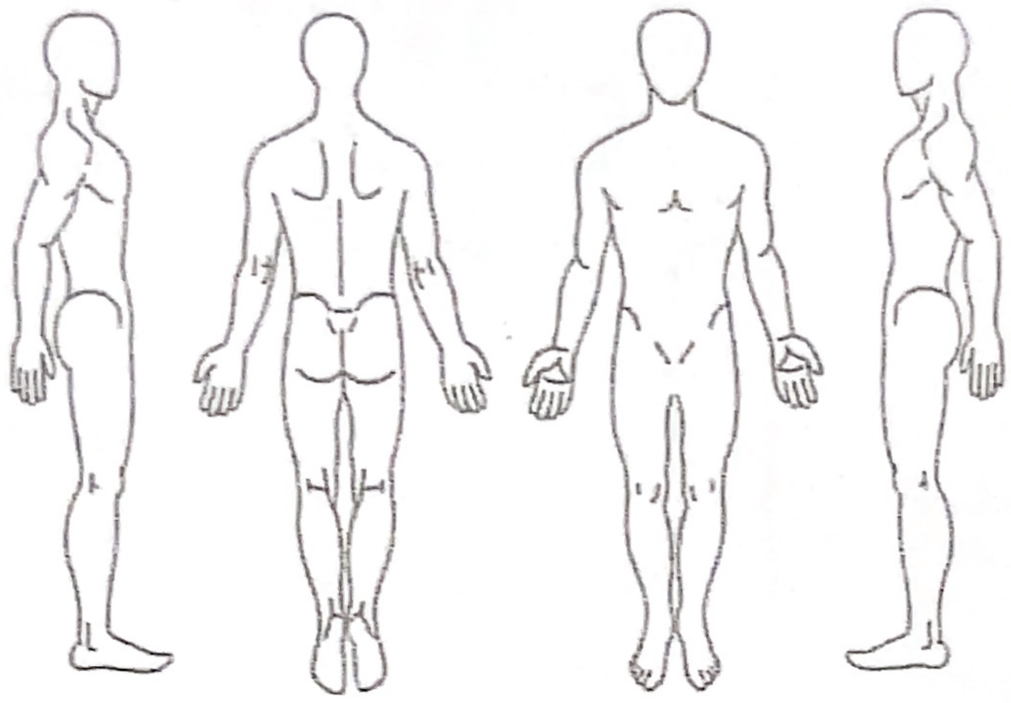
Circle Problem Areas. Circle Problem Areas:



Please list all medications you are currently taking:

_____

_____

_____

Is there anything else that your therapist should know about you or your needs before your session?

_____

_____

_____

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 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 safety and well-being.

Client Signature: _____ Date _____

Practitioner Signature: _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Laurie D'Andrea LMT, CLT to administer Manual Lymphatic Drainage techniques to my child or dependent as they deem necessary.
Signature of Parent or Guardian: _____ Date _____

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