Therapeutic Massage and Manual Lymphatic Drainage Intake Form

Name _____ Date of Initial Visit _____

Address _____

City/State/Zip _____

Age _____ Occupation _____

Email _____

Phone (Day) _____ Phone (Eve) _____

In Case of Emergency Contact _____ Phone _____

Name of Primary Care Physician: _____

Referred By: _____

Please answer the questions below. They will be used to help plan your therapy.

Y N Are you allergic or sensitive to any creams/oils (essential oils, nut oils, scents)?
If yes, please list : _____

Y N Are you pregnant? If yes, how far along are you? _____

Y N Are you currently under medical supervision?
If yes, please explain _____

Y N Are you currently taking any medication?
If yes, please list _____

Y N Do you have high or low blood pressure?
If yes, which one? _____

Do you wear _____ Contacts _____ Dentures _____ Hearing aid _____ Other _____

Are you seeking therapy for medical issues? _____

Please check any condition listed below that applies to you:

( ) skin conditions
( ) open sores or wounds
( ) easy bruising
( ) artificial joint
( ) sprains/strains
( ) arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) Fibromyalgia
( ) TMJ
( ) recent accident or injury _____
( ) recent fracture _____
( ) recent surgery _____
( ) cancer _____

( ) circulatory problems
( ) varicose veins
( ) deep vein thrombosis/blood clots
( ) heart attack or heart problems
( ) epilepsy
( ) headaches/migraines
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) _____
( ) _____
( ) _____

Please check all that apply to you.

☐ Fever ☐ Dizziness ☐ Nausea ☐ Seizures ☐ Abdominal pain ☐ Fatigue

☐ Sinus congestion ☐ Currently Menstruating or Pregnant ☐ Asthma

☐ Pneumonia / Lung disease ☐ Kidney Problems/Infections/Stones ☐ Liver Disease

☐ Swelling ☐ Lymph Nodes Removed _____

☐ Heart Attack/Problems ☐ Thyroid Disease ☐ Stroke ☐ Diabetes

☐ Undergoing Cancer Treatments _____

Please describe your main complaint including where it is and its severity.

_____

Any information (medical or other) about the conditions you marked or not specified above that you feel is important for the practitioner to know:

_____

_____

_____

_____

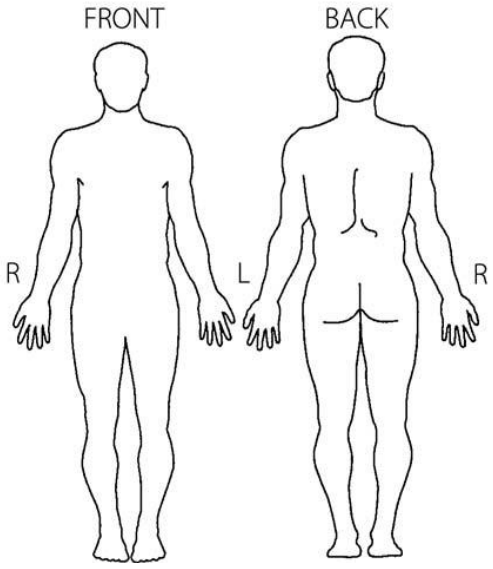
_____

_____

_____

_____

Please mark on the pictures below the location of your complaints.



Client Waiver Form

Please take a moment to read the following statements:

_____I affirm that I have notified my therapist of all known medical conditions and injuries and that I will notify my therapist of any changes in my health and medical condition.

_____I understand that massage is entirely therapeutic and non-sexual in nature.

_____If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort.

_____I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

Lymphatic Drainage

_____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.

_____Because Lymphatic Drainage 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 I 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 powerful modality and certain medical conditions are contraindicated. 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.

_____I understand that should I cancel an appointment less than 24 hours before the schedule time or "no show" an appointment, I am subject to a fee equal to the cost of the missed appointment.

Consent to Treatment of Minor

By my signature below, I hereby authorize bodywork treatment to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____Date _____

I have read and agree to the policies therein.

Patients Name _____

Signature _____Date_____

Therapist _____

THERAPEUTIC FLOW