Client Information

Client Name _____ Date _____

Address _____ City, State & Zip _____

Phone _____(Circle: cell / home / work) Email_____

I prefer to receive appointment reminders via ❑ Text ❑ Phone/Voicemail ❑ Email

DOB ____/_____/_____ Occupation _____ Referred by _____

Emergency Contact _____ Phone _____

Have you had previous Manual Lymph Drainage? ❑ Yes ❑ No

Are you presently under the care of a physician, chiropractor, physical therapist, OT, CLT or other health care practitioner? ❑ Yes ❑ No May I contact? ❑ Yes ❑ No

Name/Phone _____

Please indicate your reason for seeking treatment:_____

_____

Health Information

List all major surgeries and injuries and dates:

_____

_____

_____

List all medications currently taking (use other side if needed):

_____

_____

Check all that apply:

- ❑ allergies
- ❑ auto-immune disorder
- ❑ breast implants
- ❑ blood clots
- ❑ cancer
- ❑ chronic pain syndrome
- ❑ contact lenses
- ❑ diabetes, type 1/ type 2
- ❑ epilepsy
- ❑ fibromyalgia
- ❑ hair piece / wig
- ❑ headaches / migraines
- ❑ heart disease
- ❑ high blood pressure
- ❑ hyperthyroidism
- ❑ lyme disease
- ❑ lymph nodes removed
- ❑ lymphedema
- ❑ pacemaker
- ❑ phlebitis
- ❑ PMS syndrome
- ❑ pregnant
- ❑ psoriasis / eczema
- ❑ rheumatoid arthritis
- ❑ scarring
- ❑ undiagnosed lumps
- ❑ varicose veins

Please read and sign:
I understand that Manual Lymph Drainage (MLD) is for the purpose of fluid movement; and that the therapist does not diagnose illness, disease, or any other physical or mental disorder, or prescribe medical treatment. Information exchanged during the session is educational in nature and intended to help me become more conscious of my own health status. I have reported all my existing medical conditions and agree to report any changes as they occur. I understand I have the right to refuse treatment at any time during the session. I consent to have MLD and do not hold the therapist liable for complications that may arise as a result of the therapy.
Please note: MLD is contraindicated for untreated congested heart failure, active infections, deep vein thrombosis, and fever. There are other relative contraindications that may apply, unless approved and referred by a physician. When no referral is provided the therapist reserves the right to refuse treatment.

Client Signature _____ Date _____