

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 (use other side if needed):

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

Check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> fibromyalgia / chronic pain | <input type="checkbox"/> PMS syndrome |
| <input type="checkbox"/> auto-immune disorder | <input type="checkbox"/> headaches / migraines | <input type="checkbox"/> pregnant |
| <input type="checkbox"/> breast implants | <input type="checkbox"/> heart disease | <input type="checkbox"/> psoriasis / eczema |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> renal dysfunction |
| <input type="checkbox"/> cancer | <input type="checkbox"/> implanted devices | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> chronic vein insufficiency | <input type="checkbox"/> lyme disease | <input type="checkbox"/> scarring |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> lymph nodes removed | <input type="checkbox"/> thyroid disorder |
| <input type="checkbox"/> DVT/history of DVT | <input type="checkbox"/> lymphedema | <input type="checkbox"/> undiagnosed lumps |
| <input type="checkbox"/> diabetes, type 1/ type 2 | <input type="checkbox"/> pacemaker | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> phlebitis | |

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 _____