Lymphatic Drainage Massage Intake

Name: _____ Date of Birth: _____

Address: _____

_____

Home Phone: _____ Cell: _____ circle preferred (H) or (C)

Email: _____

Emergency Contact:: _____ Phone: _____

Referred By: _____

Have you had Lymphatic Drainage before? **Y** **N**

If yes, approximately how long ago was your last session? _____

For what reason are you seeking Lymphatic Drainage? **Relaxation** ___ **Medical** ___

Please describe why you are seeking Lymphatic Drainage:

_____

If you are here for a medical issue, when did the problem start? _____

Are you currently under treatment for oncology? **Y** **N**

If yes, what are you being treated for and where are you at in your treatment?

_____

Any recent surgeries? **Y** **N**

If yes, what?

_____

Are you on any medications? **Y** **N**

Please indicate: _____

Are you pregnant? **Y** **N**

If yes, how many weeks? _____

PLEASE CIRCLE IF YOU HAVE, OR HAVE A HISTORY OF THE FOLLOWING:

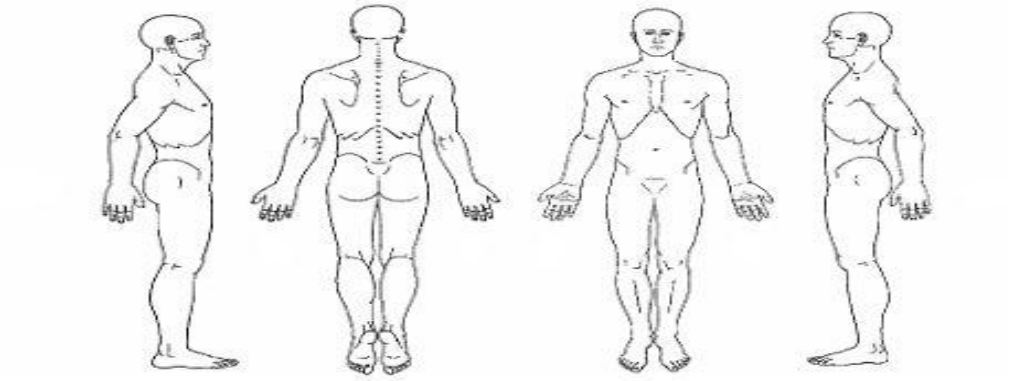
Headaches	**Arthritis**	**High Blood Pressure**	**Diabetes**
Epilepsy	**Diabetes**	**Circulatory Problems**	**Lymph Nodes Removed**
Joint Pain	**Allergies**	**Cancer**	**Digestive Issues**
Sinusitis	**Constipation**	**Varicose Veins**	**Cardiac Problems**
Jaw Pain/ TMJ	**Tendonitis**	**Fibromyalgia**	**Depression / Anxiety**
Edema	**Lymphedema**	**Acute Infection**	**Fever**

Please explain: _____

Do you have any injuries or medical conditions not listed here? **Y** **N**

Please explain: _____

PLEASE CIRCLE ANY AREAS OF TENSION OR DISCOMFORT



I understand that massage/ bodywork is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/ or technique may be adjusted to my level of comfort.

I further understand that massage/ 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 that I am aware of.

Because massage/ bodywork is contraindicated (should not be performed) under certain medical conditions, I affirm that I have stated all of my known medical conditions and answered all the 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 neglect to do so..

Signature: _____ Date: _____