LYMPHATIC DRAINAGE

Intake Form

CLIENT INFORMATION

Name:_____ Date Of Birth:_____

Address:_____

Phone:_____ Email: _____

Physician:_____Phone:_____

Emergency Contact:_____Phone:_____

How did you hear about us? _____

YOUR HEALTH HISTORY

For what reason are you seeking manual lymphatic drainage?
_____ Medical reason _____ Relaxation

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? _____ Yes _____ No

With what have you been diagnosed, if so? _____

Have you been cleared by your doctor to receive manual lymphatic drainage?
_____ Yes _____ No

Have you received surgery? _____ Yes _____No

Have you received surgery? _____Yes _____No

If so, have you received manual lymphatic drainage after surgery? _____Yes _____No

How any sessions? _____

Please mark all surgeries/procedures:
_____ Breast Augmentation
_____ Breast Removal
_____ Breast Lift
_____ Abdominoplasty (Tummy Tuck)
_____ Brazilian Butt Lift (BBL)
_____ Hip Augmentation
_____ Neck Surgery
_____ Shoulder Surgery
_____ Knee Surgery
_____ Leg Surgery
_____ Hip Surgery
_____ Back Surgery
_____ Foot Surgery

Have you had liposuction? _____ Yes _____ No

If you have had liposuction, where and what kind? _____

List the information on any previous surgeries you've had below:

Date: _____ Hospital/Clinic: _____ Surgeon: _____

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CURRENT & PREVIOUS CONDITIONS

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 arrythmia
_____ Other: _____

Gastrointestinal:
_____ Crohn's disease
_____ Abdominal pain
_____ Surgical implant (mesh or other)

Urinary:
_____ Kidney failure
_____ Kidney stones
_____ Urinary tract infections
_____ Dialysis
_____ 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: _____

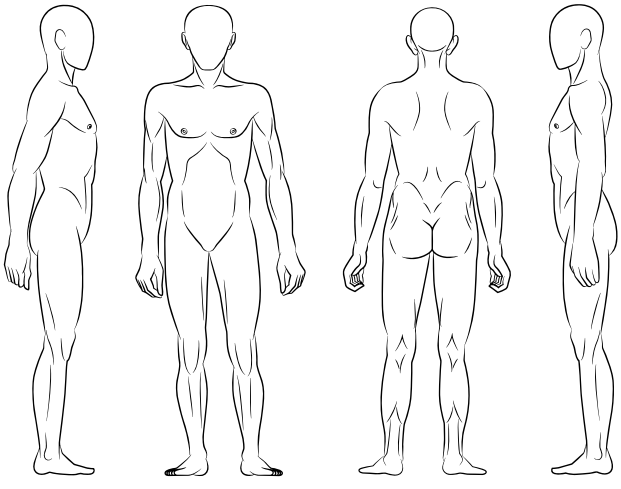
Allergies:
_____ Ear fullness
_____ Sinus congestion
_____ Recent sinus surgery
_____ Other: _____

Emotional:
_____ Stress
_____ Anxiety
_____ Difficulty sleeping
_____ Depression
_____ Other: _____

Please list all medications you are taking and the reason for the prescription: _____
_____

TREATMENT PLANNING

Circle problem area:



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

RELEASE & CONSENT

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Client Signature: _____ Date: _____