BODYCONSCIOUS
MASSAGETHERAPY

Lymphatic Massage Intake Form

Name: _____ Today's Date: _____
Are you a new Body Conscious Client? Yes No-(Please skip to health history portion).
Address: _____
Phone: _____ Email: _____

Emergency Contact: Name _____ Phone: _____
Relationship to client: _____ Referred by: _____

Personal Health History: Please write down past or current symptoms for each category

Abdominal pain	High blood pressure
Allergies	HIV/AIDS
Arthritis	Infection
Aneurysm	Kidney infections/stones
Autoimmune disorder	Liver Disease
Bowel problems	Low Blood pressure
Blood clots	Lung Disease
Broken bones	Migraine Headaches
Bruise Easily	Major organ failure
Cancer:	Major scars
Cardiovascular problem:	Musculoskeletal
Chronic Bronchitis	Nausea
Chronic Constipation	Neurologic Issues
Chronic Ear infections	Neuropathy
Congestive Heart Failure	Pneumonia
Clotting	Pregnancy
Deep vein thrombosis	Sinus congestion or problems
Depression/Anxiety	Skin issues
Diabetes	Stroke
Enlarged lymph nodes	Surgery
Fatigue	Swelling
fever	Tinnitus
Fibrocystic Breast	Thyroid Disorder/disease
Gastrointestinal Issues	Transient Ischemic Attack
Heart Attack	Weight gain
Head Injury/Concussion	Other:
Hematologic/Lymphatic issues	

What is the reason you are seeking lymphatic massage today? _____

For Cancer Clients:
Are you currently undergoing cancer treatments? _____
If yes, do you have written permission from your treatment team, to receive Manual Lymphatic Drainage, at this time?_____
If no, what was the date of your last treatment?_____

For Prenatal Clients:
Are you still experiencing morning sickness?_____
Have you been told you are a high risk pregnancy?_____ If Yes, Do you have written permission from your Obstetrician to receive Manual lymph drainage at this time?_____

For Medical Referral Clients:
Do you give your therapist permission to consult with your referring provider your protected health information for the purpose of this visit? No____Yes- (Please sign HIPAA Form.)

Medications currently taking:
_____
Please provide any other information, medical or otherwise, not specified in this intake form that you feel is important for the therapist to know:_____

**Please note: Manual Lymphatic Drainage (MLD) aka Lymphatic Massage, is a very powerful modality, and certain medical conditions are contraindicated and determine if and when you can receive a session. After 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, or consultation between your referring provider and lymphatic therapist, before proceeding. Please understand this is for your safety and well-being.*
I understand that manual lymphatic drainage should not be considered a substitute for medical examination, diagnosis, or treatment, and I should see a physician, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that lymphatic therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the sessions should be construed as such.

Manual 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 and to the best of my knowledge. 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 practitioners part should I fail to do so.

Client Signature_____Date:_____
Practitioner Signature:_____Date:_____

Consent to treatment of Minor :
By my signature below, I hereby authorize the certified manual lymphatic drainage therapist, to administer manual lymphatic drainage to my child or dependent as they deem necessary.

Signature of Parent/Guardian:_____ Date:_____