LYMPHATIC MASSAGE INTAKE

Name: ______________________________ Phone: ______________

E-Mail Address: ____

Physical Address: __________________________________ Zip: ________

Date of Birth: ______________ How did you hear about us?______________________

Emergency Contact: _______________ Relation: ____________ Phone: ______________

Manual Lymphatic Drainage (MLD) is a gentle treatment to speed up the movement of lymph fluid to relieve pain and swelling, assist the body's own healing processes, boost immunity, and reduce the chance of scar formation. The pressure used during this session is extremely light (the pressure of the weight of a nickel.) If deeper pressure is used, the session will not be as effective with its results and could exacerbate the condition. Thank you for understanding.

Are you pregnant? ❑ Yes ❑ No If yes, what trimester? ________ Current athletic ability: ❑ Poor ❑ Average ❑ Good

Which service(s) have you experienced? ❑ Massage ❑ Acupuncture ❑ Yoga ❑ Reiki ❑ Other ______________

Have you been involved in an accident, had surgery, or been hospitalized in the last 3 years? ❑ Yes ❑ No

List any chronic conditions that you deal with on a regular basis: ______________________________

Are you taking any medications or herbs? ❑ No ❑ Yes (specify) ______________________________

Do you have any allergies (especially to nuts)? ❑ No ❑ Yes (specify) ______________________________

Have you had Manual Lymphatic Drainage Therapy (MLD) ❑ Yes ❑ No

Name of therapist/spa/office where you have had these sessions ______________________________

For what reason are you seeking Manual Lymphatic Drainage? ❑ Medical Reason ❑ Relaxation

If medical reason, please explain?

____

Physician/Surgeon Contact Name ______________________________ Phone ______________

Have you already received Manual Lymphatic Drainage after surgery? ❑ Yes ❑ No How many sessions? __________

During your massage, are you **unable** to lie on your ❑ Stomach ❑ Back ❑ Side?

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PLEASE MARK ALL SURGERIES AND DATES

COSMETIC SURGERIES			OTHER
LIPOSUCTION	BREAST	❑ Neck ________	
❑ 360 ______________	❑ Augmentation ______________	❑ Shoulder ______	
❑ Abdomen _________	❑ Removal __________________	❑ Knee ________	
❑ Waist/Flanks _______	❑ Lift _______________________	❑ Leg _________	
❑ Arms ______________	OTHER	❑ Hip _________	
❑ Hips ______________	❑ Abdominoplasty (Tummy Tuck) _______	❑ Back ________	
❑ Thighs ___________	❑ Brazilian Butt Lift (BBL) _____________	❑ Foot ________	
❑ Back ____________	❑ Hip Augmentation _________________		
❑ Neck ____________			

PLEASE MARK ALL CURRENT AND PREVIOUS CONDITIONS THAT APPLY TO YOU

GENERAL
- ❑ Fever
- ❑ Arteriosclerosis
- ❑ Carotid Sinus Issues
- ❑ Hyperthyroidism
- ❑ Liver Cirrhosis

EARS, NOSE, THROAT
- ❑ Ringing in Ears
- ❑ Sinus Problems
- ❑ Earaches

FEMALE REPRODUCTIVE
- ❑ Currently Pregnant
- ❑ Currently Menstruating
- ❑ Fibrocystic Breast Disease
- ❑ IUD

NEUROLOGICAL
- ❑ Strokes
- ❑ Seizures

MUSCULOSKELETAL
- ❑ Osteoporosis
- ❑ Osteoarthritis
- ❑ Hernia
- ❑ Rheumatoid Arthritis
- ❑ 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 Arrhythmia
- ❑ Other

GASTRO - INTESTINAL
- ❑ Crohn's Disease
- ❑ Abdominal Pain
- ❑ Surgical Implant (mesh or other)
- ❑ GI Inflammation
- ❑ Diverticulitis/Diverticulosis
- ❑ Other

URINARY
- ❑ Kidney Failure
- ❑ Kidney Stones
- ❑ Urinary Tract Infection
- ❑ Dialysis
- ❑ 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

ALLERGIES
- ❑ Ear Fullness
- ❑ Sinus Congestion
- ❑ Recent Sinus Surgery
- ❑ Other

EMOTIONAL
- ❑ Stress
- ❑ Anxiety
- ❑ Difficulty Sleeping
- ❑ Depression
- ❑ Other

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FOR CANCER FIGHTERS

Are you currently undergoing cancer treatments? ❑ Yes ❑ No

- If yes, do you have written permission from your treatment team to receive Manual Lymphatic Drainage at this time? ❑ Yes ❑ No
- If no, what was the date of your last treatment? ______________________

Type of cancer and location ______________________

Date of diagnosis ______________________

Are you experiencing any pain? If yes, where? ______________________

Have you had lymph nodes removed? ❑ Yes ❑ No If yes, from where?______________________

Number of nodes removed ______________________

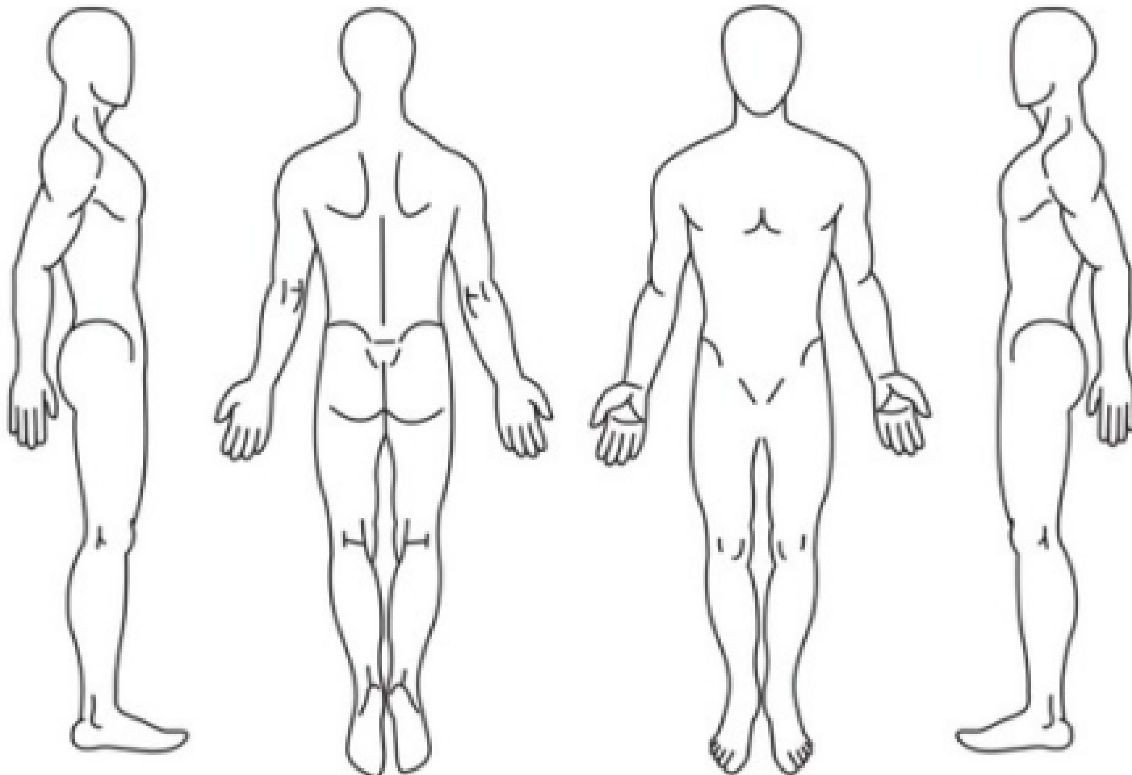
Cancer Related Surgery*	❑ Yes	❑ No	❑ Ongoing	Completion Date ______________
Reconstruction	❑ Yes	❑ No	❑ Ongoing	Completion Date ______________
Chemotherapy	❑ Yes	❑ No	❑ Ongoing	Completion Date ______________
Radiation	❑ Yes	❑ No	❑ Ongoing	Completion Date ______________

- List surgeries here:

  ____

  ____

MARK PAINFUL OR DISTRESSED AREAS



LYMPHATIC MASSAGE INTAKE

Agreement of Release and Waiver of Liability (*please read and sign)*

I understand that the Manual Lymphatic Drainage (MLD) I receive is provided for the basic purpose of improving the flow of my lymphatic system and also for relaxation. If I experience any pain or discomfort during my session. I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

Manual Lymphatic Drainage is a very powerful modality and certain medical conditions are contradicted and determine if or when you can receive a session. After the 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 before proceeding. Please understand this is for your safety and well-being.

I understand that canceled or missed appointments without 24-hour notice (medical emergencies excluded) may be charged in full for the price of missed session.

I understand the service(s) I am receiving may be contraindicated for specific medical conditions and symptoms. I further understand the services are not substitutes for medical care and that therapists for these services do not diagnose disease, prescribe medicine or manipulate bones. If at any time during the service I feel uncomfortable, I may end the session. I take responsibility for alerting my therapist or instructor to any changes that occur with my health.

I understand that draping of the breast will be used at all times for female clients during each session for massage and cupping, and therapists will not massage the breasts without written consent. I understand that draping of the genital area and gluteal cleavage will be used at all times for all clients during each session for massage and cupping.

Therapist will immediately end the session if a client initiates any verbal or physical contact that is sexual in nature.

I knowingly, voluntarily, and expressly waive any claim I may have against Serasana, its owners, employees or therapists for injury or damages that I may sustain as a result of my participation. I, my heirs or legal representatives forever release, waive, discharge and covenant not to litigate Serasana, its owners, employees or therapists for any injury or death caused by their negligence or other acts.

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Client signature: ____ **Date:** _______________________

If under 17 years, signature of legal guardian: _______________________________ **Date:** _______________________

Therapist's signature (if applicable): ______________________________________ **Date:** _______________________