Healthy Life Transformations

Lymphatic Drainage Massage Intake Form

Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip _____

Phone: (Home)_____ (Cell)_____ E-mail: _____

Emergency Contact: _____ Phone: _____

Employer/Occupation: _____

Reason/Goals for Visit: _____

Have you ever had lymphatic drainage massage before? _____

For what reason are you seeking Lymphatic Drainage Massage?

_____

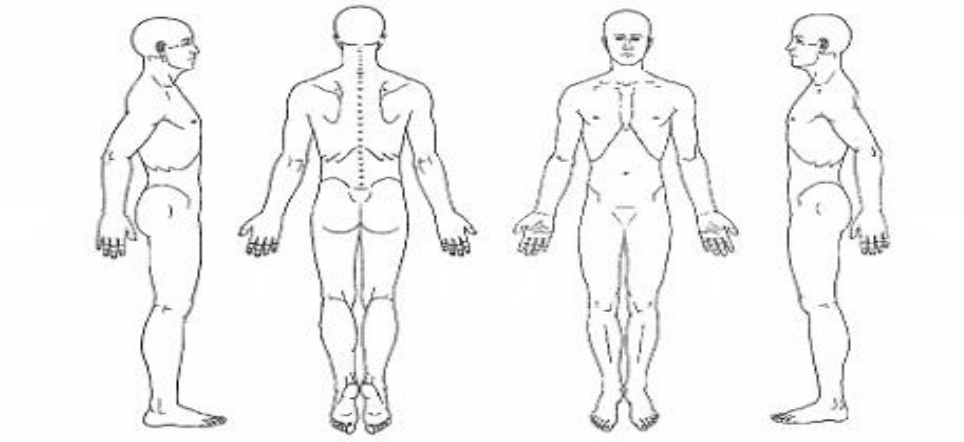
Please describe your problem including where it is and its severity.

_____

_____

_____

Please circle all affected areas.



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General		Female Reproductive	
Fever		Currently pregnant	
Undergoing cancer treatment		Currently menstruating	
Last chemotherapy session		Fibrocystic breast disease	
Arteriosclerosis		IUD	
Carotid sinus issues		Other:	
Hyperthyroidism		Musculoskeletal	
Liver Cirrhosis		Osteoporosis	
Other:		Osteoarthritis	
Ears, Nose, Throat		Hernia	
Ringing in ears		Rheumatoid arthritis	
Sinus problems		Other:	
Earaches		Skin	
Other:		Cellulitis	
Cardiovascular		Rash	
Chest pain or pressure		Major scars	
Swelling of legs		Lumps	
Palpitations		Other:	
Varicose veins		Hematologic/ Lymphatic	
Dizziness		Cuts that do not stop bleeding	
Acute deep vein thrombosis		Enlarged lymph nodes (glands)	
Congestive heart failure		Lymph nodes removed	
Heart attack		Frequent bruising	
High/Low blood pressure		HIV/AIDS:	
Aneurysm		Other:	

Cardiac arrhythmia		Neurological	
Other:		Strokes	
Gastro-Intestinal		Seizures	
Crohn's disease		Other:	
Abdominal pain		Allergies	
Surgical implant(mesh or other)		Ear fullness	
GI inflammation		Sinus congestion	
Diverticulitis/Diverticulosis:		Recent sinus surgery	
Other		Other:	
Urinary		Emotional	
Kidney failure		Stress	
Kidney stones		Anxiety	
Urinary tract infection		Difficulty sleeping	
Dialysis		Depression	
Other:		Other:	

Please list all surgeries (including Cesarean section).

Surgery	Date

Please list all medications, and supplements/vitamins/herbs.

Medication	Reason

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

_____

_____

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LYMPHATIC DRAINAGE MASSAGE AGREEMENT/ACKNOWLEDGEMENT

I understand that the Lymphatic Drainage Massage 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 this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage or 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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all 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 fail to do so.

*Please Note: Lymphatic Drainage Massage (LDM) is a very powerful modality and certain medical conditions are contraindicated and determine if and 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 LDM 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 acknowledge and voluntarily assume the risk of injury, accident or death which may arise from lymphatic massage drainage. I and any of my heirs, executors, representatives, or assigns hereby release for the all claims or liabilities for personal injury or property damages of any kind sustained while on the premises, during the lymphatic drainage massage and from any advice provided by an employee, independent contractor or any representative. I agree that this Application and Waiver is in effect for all lymphatic drainage massage sessions and will not expire unless specifically requested by either party.

Client Printed Name: _____

Client Signature: _____ Date _____

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