Denice Buchanan, LMT
Manual Lymphatic Drainage
Massage Intake Form

Personal Information

Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____) _____ Email: _____
Occupation: _____
Emergency Contact: _____ Phone: (_____) _____

Referred by/How did you hear about us?
_____

May we send you special offers via email?
☐ Yes ☐ No

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

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

For cancer patients:
Are you currently undergoing cancer treatments? ☐ Yes ☐ No
- If Yes, do you have written permission from your treatment team to receive MLD at this time? ☐ Yes ☐ No
- If No, what was the date of your last treatment? _____

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? _____
Have you been cleared by your doctor to receive MLD? ☐ Yes ☐ No
Have you received surgery? ☐ Yes ☐ No
If so, have you received MLD after surgery? ☐ Yes ☐ No How many sessions? _____

Please mark ALL surgeries/procedures

Common Cosmetic Surgeries		Common Surgeries	Other
☐ Liposuction: ☐ 360 ☐ Abdomen ☐ Waist/Flanks ☐ Arms ☐ Hips ☐ Thighs ☐ Back ☐ Neck	☐ Breast ☐ Augmentation ☐ Removal ☐ Lift ☐ Abdominoplasty (Tummy Tuck) ☐ Brazilian Butt Lift (BBL) ☐ Hip Augmentation	☐ Neck ☐ Shoulder ☐ Knee ☐ Leg ☐ Hip ☐ Back ☐ Foot	_____ _____ _____ _____ _____ _____

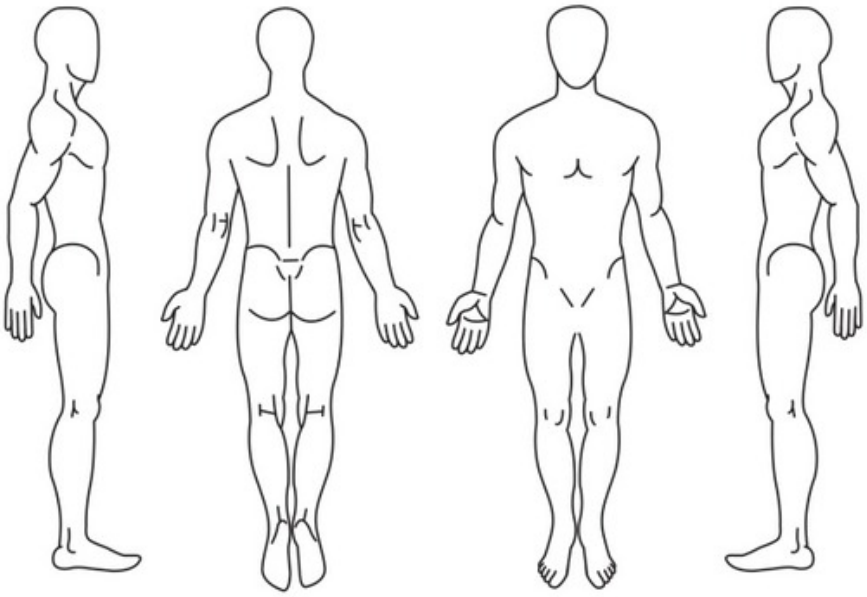
Surgery Date	Hospital / Clinic	Surgeon

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 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:	

Female Reproductive	
Currently pregnant	
Currently menstruating	
Fibrocystic breast disease	
IUD	
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:	

Circle problem area:



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

_____

_____

_____

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

_____

_____

_____

I understand that the Manual Lymphatic Drainage 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: Manual Lymphatic Drainage (MLD) is a very powerful modality and certain medical conditions are contraindicated 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.

Client Signature: _____ Date _____

Practitioner Signature: _____ Date _____

Consent to Treatment of Minor: *By my signature below, I hereby authorize Denice Buchanan, LMT, to administer Manual Lymphatic Drainage techniques to my child or dependent as they deem necessary.*
Signature of Parent or Guardian _____ *Date* _____