Manual Lymph Drainage Massage
Health Intake Form

Name:_____Date:_____Email:_____
Home Address:_____Phone #:_____
Have you ever received a professional massage?___No____Yes. If yes, date of last massage_____
Are you currently seeing a health care practitioner?___No___Yes. If yes, please explain_____
_____
List current medications, herbals & supplements and reason for use. Please include OTCs such as aspirin, ibuprofen, Claritin, etc._____
_____
Previous surgeries (in last 2 years)_____
Previous Accidents:_____

HEALTH HISTORY

GENERAL: ABSOLUTE:

___Acute cellulitis

___Untreated congestive heart failure
___Acute untreated deep venous thrombosis
___Fever

GENERAL: RELATIVE:

___Malignant disease (complications & effects from the disease, not the disease itself)
___Renal dysfunction

NECK:

___Cardiac arrhythmia
___Hyperthyroidism
___Hypersensitivity of the carotid sinus
___History or risk of Arteriosclerosis
___Stroke

DEEP TRUNK:

___Osteoporosis
___Radiation fibrosis
___Bone metastases
___Hormone therapy (i.e. Tamoxifen)

ABDOMINAL:

___Pregnant
___Menstrual Period
___Abdominal surgery within last 6 months
___Radiation fibrosis
___Radiation colitis
___Radiation cystitis
___After pelvic deep vein thrombosis (within last 6 months)
___Chrohn's disease
___Diverticulitis and Diverticulosis
___Liver cirrhosis
___Abdominal aortic aneurysm (even following surgical repair)
___Unexplained pain
___Implanted devices (drains, tubes, colostomy bag, etc)
___Others (hernia, bladder mesh, lap bands, gastric bypass surgery, fibroids, ovarian cysts, adhesions from endometriosis, repeated surgeries, pain patches, hormone patches)

IF ACTIVE CANCER:

___48 hrs since last chemo treatment?
___Radiation area locations_____
_____

If any areas are marked in the GENERAL categories above, an MLD can't be performed at this time.

Client signature:_____Date:_____
Therapist Signature:_____Date:_____