



East Windsor, NJ 08520
 www.MendYourBodyMassage.com
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Manual Lymphatic Drainage Form

Contact Information

Date: _____

Name: _____

Address: _____

City, State, Zipcode: _____

Phone Number: _____ Email: _____

Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Physician/Surgeon: _____ Phone: _____

Referred By: _____

How did you find Mend Your Body Massage?: _____

Health History

Before treatment begins, it is very important that any recent or chronic medical conditions and any medications you may be taking be discussed. If you have any of these conditions, it may preclude you from receiving your bodywork, so please be honest and update me regularly of any medical changes.

Have you ever or are you currently experiencing any of the following?		
	Yes	No
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Liver Failure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots *Unmanaged in the last 2 years	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (what kind) _____	<input type="checkbox"/>	<input type="checkbox"/>
High Risk Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Infections	<input type="checkbox"/>	<input type="checkbox"/>
Open Wounds	<input type="checkbox"/>	<input type="checkbox"/>
Unidentified Rashes or Lumps on Your Body	<input type="checkbox"/>	<input type="checkbox"/>

If you answered Yes, please explain further: _____

Treatment Plan

**Please Note: Some conditions will require a note from your doctor before proceeding. Please understand this is for your safety and well-being. Your health is important to me.*

1. Why are you seeking Manual Lymphatic Drainage? _____

2. What do you hope to accomplish? _____

3. Are you currently taking any medication? _____

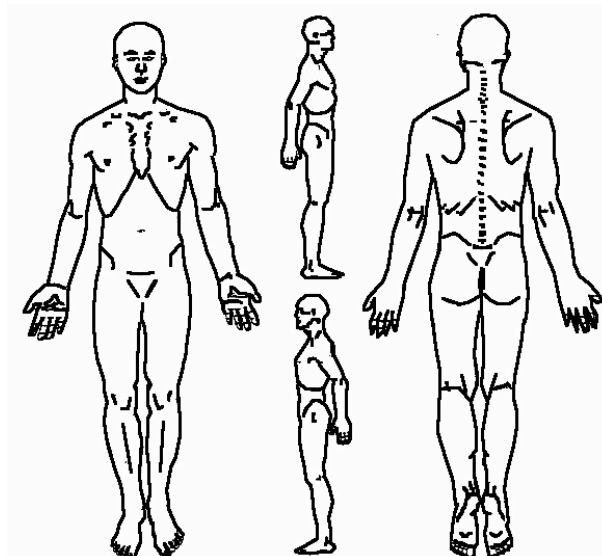
4. Describe any major injuries, accidents, surgeries, or hospitalizations (include year of event):

5. What kind of care did you receive? _____

6. Do you consider yourself recovered from these events? Please explain: _____

7. Do you have any skin allergies? _____
8. Are you currently seeing a doctor or alternative therapist for any reason? Please explain:

**In order to create the most beneficial session,
please circle all affected areas and on the following page,
mark all current and previous conditions that apply.**



General		Female Reproductive	
Fever	<input type="checkbox"/>	Currently pregnant	<input type="checkbox"/>
Undergoing cancer treatment	<input type="checkbox"/>	Currently menstruating	<input type="checkbox"/>
Last chemotherapy session	<input type="checkbox"/>	Fibrocystic breast disease	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	IUD	<input type="checkbox"/>
Carotid sinus issues	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>	Musculoskeletal	
Liver Cirrhosis	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>
Other:	<input type="checkbox"/>	Hernia	<input type="checkbox"/>
Ears, Nose, Throat		Rheumatoid arthritis	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	Skin	
Earaches	<input type="checkbox"/>	Cellulitis	<input type="checkbox"/>
Other:	<input type="checkbox"/>	Rash	<input type="checkbox"/>
Cardiovascular		Major scars	<input type="checkbox"/>
Chest pain or pressure	<input type="checkbox"/>	Lumps	<input type="checkbox"/>
Swelling of legs	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	Hematologic/ Lymphatic	
Varicose veins	<input type="checkbox"/>	Cuts that do not stop bleeding	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Enlarged lymph nodes (glands)	<input type="checkbox"/>
Acute deep vein thrombosis	<input type="checkbox"/>	Lymph nodes removed	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	Frequent bruising	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	HIV/AIDS:	<input type="checkbox"/>
High/Low blood pressure	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Aneurysm	<input type="checkbox"/>	Neurological	
Cardiac arrhythmia	<input type="checkbox"/>	Strokes	<input type="checkbox"/>
Other:	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Gastro-Intestinal		Autism	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	Allergies	
Surgical implant(mesh or other)	<input type="checkbox"/>	Ear fullness	<input type="checkbox"/>
GI inflammation	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>
Diverticulitis/Diverticulosis	<input type="checkbox"/>	Recent sinus surgery	<input type="checkbox"/>
Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Urinary		Emotional	
Kidney failure	<input type="checkbox"/>	Stress	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Urinary tract infection	<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>

Please provide more details to any symptoms you have: _____

Describe any treatments you have already received for your current condition (including Doctor Appointments, PT, Massage, Medications, Surgeries, etc): _____

Please describe any other information (medical or other) not mentioned thus far on the form that you feel is important for your therapist to know: _____



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Please read the following statement carefully, then sign below.

I acknowledge the Manual Lymphatic Drainage I receive is provided for the basic purpose of improving the flow of my lymphatic system. If I experience any pain or discomfort during this session, I will immediately inform the therapist so the pressure, strokes, or position may be adjusted to my level of comfort. I will inform the therapist if I require the session to end prematurely and agree to provide full payment of the scheduled session, including travel fees if applicable.

I further understand any bodywork I receive is not a substitute for medical examination and/or diagnosis and that it is recommended that I see a physician for any physical ailment I may have. I have stated all known medical conditions and take it upon myself to keep the therapist updated on my physical and mental health. I understand that there shall be no liability on the practitioner's part should I fail to do so.

By signing this form, I grant permission to Mend Your Body Massage LLC to use photographs and/or videos taken by the company or those provided by me. I grant permission to use, reproduce, edit, exhibit, display, and/or publish photographic pictures and/or moving pictures and/or videotaped images in all forms and media (including but not limited to: on social media, Mend Your Body Massage LLC website, publications, and advertising/promotions). I waive all claims to compensation and damages. I acknowledge that Mend Your Body Massage LLC will, when possible, protect my privacy and identity.

I acknowledge any illicit or sexually aggressive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of scheduled appointment, including travel fees if applicable.

I acknowledge payment is due at the time of treatment. I agree to give at least 24 hours notice of appointment cancellation. I acknowledge if the cancellation is less than 24 hours before the appointment, half the amount may be charged. I understand if I do not contact the therapist, I will be charged the full cost of the appointment, including travel fees if applicable. Emergency situations or weather related instances are considered exceptions.

I hereby release Mend Your Body Massage LLC, its affiliates, and/or employees from any liability in the aforementioned. I have carefully read and understand all of the above and I have answered all questions fully and accurately.

Client signature _____ Date _____

Note:

Manual Lymphatic Drainage (MLD) is a very powerful modality and certain medical conditions may 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 MLD should be administered to you.

I ask about specific conditions to ensure that receiving a session will not pose any risk to either you or the therapist. Bodywork can have a powerful effect on our bodies, even if it's just for "relaxation". Some conditions benefit from specific types of bodywork while other may be exacerbated by local and systemic effects. I thank you for your cooperation and hope you enjoy your session.