East Windsor, NJ 08520
www.MendYourBodyMassage.com
Mendyourbodymassage@gmail.com
Phone: 609-529-1094 Fax: 609-371-2503

Manual Lymphatic Drainage Form

Contact Information Date: _____

Name: _____

Address: _____

City, State, Zipcode: _____

Phone Number: _____ Email: _____

Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referred By:_____

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	☐	☐
Liver Failure	☐	☐
Kidney Failure	☐	☐
Blood Clots *Unmanaged in the last 2 years	☐	☐
Cancer (what kind)	☐	☐
High Risk Pregnancy	☐	☐
Fever	☐	☐
Pain	☐	☐
Infections	☐	☐
Open Wounds	☐	☐
Unidentified Rashes or Lumps on Your Body	☐	☐

If you answered Yes, please explain further: _____
_____
_____

Are you currently on any type of medication?: _____
_____
_____

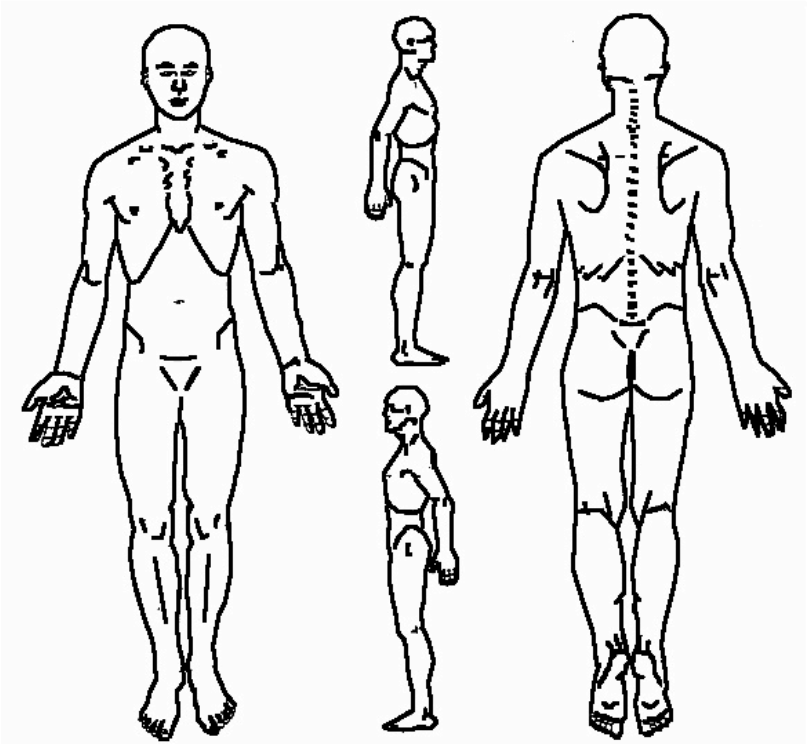
Treatment Plan

Why are you seeking Manual Lymphatic Drainage? _____
_____
_____

*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.

What do you hope to accomplish? _____
_____
_____

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	☐	Currently pregnant	☐
Undergoing cancer treatment	☐	Currently menstruating	☐
Last chemotherapy session	☐	Fibrocystic breast disease	☐
Arteriosclerosis	☐	IUD	☐
Carotid sinus issues	☐	Other:	☐
Hyperthyroidism	☐	Musculoskeletal	
Liver Cirrhosis	☐	Osteoporosis	☐
Weight Gain	☐	Osteoarthritis	☐
Other:	☐	Hernia	☐
Ears, Nose, Throat		Rheumatoid arthritis	☐
Ringing in ears	☐	Other:	☐
Sinus problems	☐	Skin	
Earaches	☐	Cellulitis	☐
Other:	☐	Rash	☐
Cardiovascular		Major scars	☐
Chest pain or pressure	☐	Lumps	☐
Swelling of legs	☐	Other:	☐
Palpitations	☐	Hematologic/ Lymphatic	
Varicose veins	☐	Cuts that do not stop bleeding	☐
Dizziness	☐	Enlarged lymph nodes (glands)	☐
Acute deep vein thrombosis	☐	Lymph nodes removed	☐
Congestive heart failure	☐	Frequent bruising	☐
Heart attack	☐	HIV/AIDS:	☐
High/Low blood pressure	☐	Other:	☐
Aneurysm	☐	Neurological	
Cardiac arrhythmia	☐	Strokes	☐
Other:	☐	Seizures	☐
Gastro-Intestinal		Autism	☐
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 provide more detail to any symptoms you have: _____

Describe any treatments you have already received for your 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 fully 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 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. I will be liable for full payment of sessions ended early.

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.

I understand that 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 payment of scheduled appointment.

I understand that payment is due at the time of treatment. I agree to give 24 hours prior notice of appointment cancellation. I understand that if the call 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 charge the full cost of the appointment. Emergency situations are considered exceptions.

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.

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Photograph Release Form

Patient Information:

Name: _____ Date of Birth: _____

Photograph Consent and Release:

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after Manual Lymphatic Drainage sessions. The photographs will be taken by Mend Your Body Massage. Any photographs taken will become part of my medical records. My photographs are to be used for the purposes of office and hospital medical records, any necessary medical treatments, and to chart progress.
I hereby give my consent for Mend Your Body Massage to use the photographs under the following conditions:

Please choose one of the following options and initial

(Please initial) _____ I authorize my photographs to be used for the purposes of: Medical Seminars, website/other advertising publications and/or office photo albums. All efforts will be made to ensure patient anonymity and confidentiality. No names or identifying references will be made in conjunction with published photography.

(Please initial) _____ I authorize my photographs to be used only for my medical record and insurance purposes of my Manual Lymphatic Drainage sessions with Mend Your Body Massage. I understand these photos *will not* be used on a website or in any publications.

Signature: _____ Date: _____