Columbia Lymphatic Massage
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Personal Information:

Client's Name _____Date ____/____/_____

Address _____ City _____ ST _____ Zip_____

Cell: _____ Age _____ Birth date ___/____/_____ Sex: F M T O

E-Mail Address _____

I give my consent to contact me via email, phone, text or mail with appointment reminders.

Who can I thank for referring you? _____

Emergency Contact _____ Phone _____ Relationship _____

Have you ever received Manual Lymphatic Drainage (MLD)? And if so, when? _____

Other types of bodywork received? _____

What are your goals for this session? _____

_____

For clients undergoing cancer treatments:

What was your diagnosis? _____

Are you currently undergoing cancer treatment? ____ YES ____ NO Radiation ____YES ____ NO

Do you have written permission from your treatment team to receive MLD at this time? ____ YES ____ NO

What was the date of your last treatment? _____

Do you give written permission to contact your treatment team to receive MLD at this time? ___ YES ___ NO

Were drains used in the procedure? ____ YES ____ NO How many? _____

Are surgical sites healed? ____ YES ____ NO

Date of last chemotherapy session? _____

How many sessions have you had? _____ How many are recommend? _____

How many radiation sessions have you had? _____ How many are recommend? _____

Please describe the full procedure and if there were any complications.

_____

_____

_____

For clients who have received cosmetic surgery procedures:

Did your surgeon recommend post surgical MLD? ___ YES ___ NO

Have you been cleared by your doctor to receive MLD? ____ YES ____ NO

If so, have you received MLD after surgery? ___ YES ___ NO

How many sessions? _____

Are you in pain? ____YES ____ NO

If so, where? _____

Are you experiencing swelling or bruising? ____ YES ____ NO

If so, where? _____

Please mark ALL surgeries/procedures:

Liposuction:
____ 360
____ Abdomen
____ Waist/Flanks
____ Arms
____ Hips/buttocks
____ Back
____ Thighs
____Inner Knee
____Calves & Ankles
____ Neck/Chin

Breast:
____ Augmentation
___ Implant
___Fat transfer
____Lift
____ Removal
____ Implant Revision
____ Revision
____ Nipple
___Removal
____Reconstruction

Body Lifts:
____Arm Lift
____Body Lift
____ Mommy Makeover
_____Body Contouring
____ Abdominoplasty
____ BBL
____ Hip Augmentation

Neck & Face
____Face lift
____Rhinoplasty
____ Eyes/Brow
____ Cheek Augmentation
____ Neck/Chin

Breast Reconstruction:
____Expanders
____Areola
____Removal
____Reconstruction

Gender Confirmation Surgery

Facial
____Transfeminine
____Transmasculine

Chest
____Transfeminine
____Transmasculine

Did you have issues with blood clots or clotting?	____ YES ____ NO
Were drains used following the procedure?	____ YES ____ NO
Were you in a compression garment?	____ YES ____ NO
Are you wearing post-surgical garments?	____ YES ____ NO
Are you noticing thickening or fibrosis?	____ YES ____ NO

Please provide all the details of your recent surgery (date, hospital/clinic, surgeon):

_____

_____

_____

_____

Please list ALL medications and reason for taking them. Please checkmark if it is related to the surgery:

_____	_____	____ YES ____ NO
_____	_____	____ YES ____ NO
_____	_____	____ YES ____ NO
_____	_____	____ YES ____ NO
_____	_____	____ YES ____ NO

Please describe and provide dates:

Prior Surgeries _____

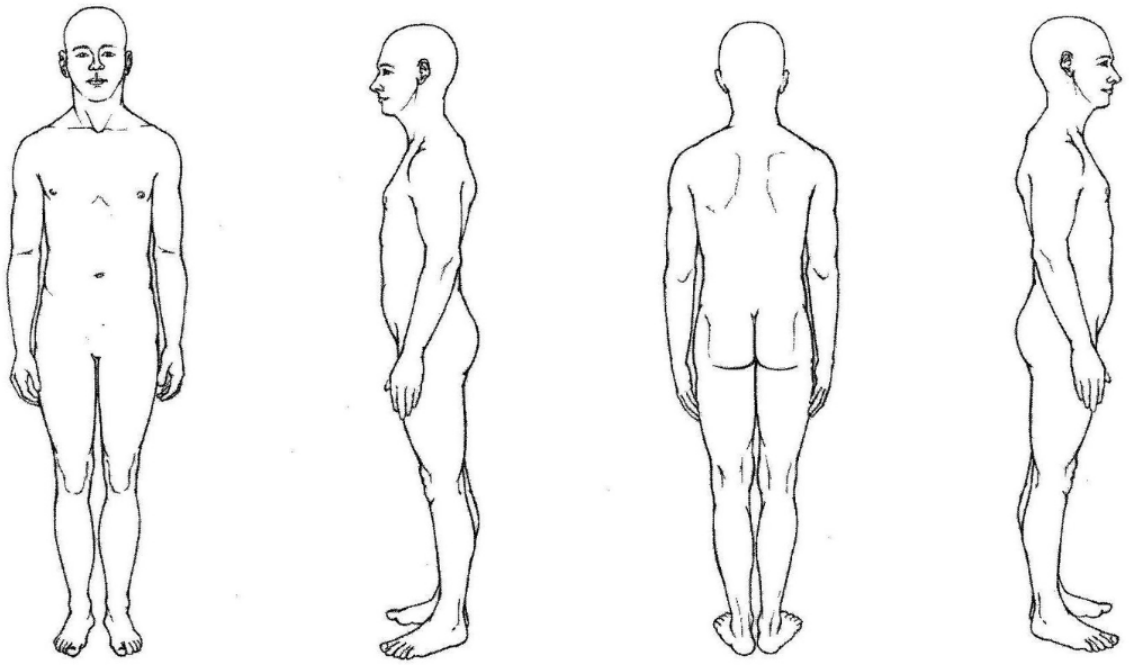
Auto Accidents _____

Falls/Injuries _____

Pregnancies _____

Are you currently pregnant? _____

Please mark all areas that apply to your surgery.



Health History
Please mark C for a current condition, P if a past condition and leave blank if not applicable.

____Abdominal Pain
____ADD/ADHD
____AIDS/HIV
____Allergies
____Aneurysm
____Ankle/Foot Pain
____Anorexia
____Anxiety
____Appendicitis
____Arm Pain
____Arthritis
____Asthma
____Auto Accident
____Autoimmune Disorder
____Back Pain
Blood Pressure
____High
____Low
____Blood Clots
____Blood Thinner
____Broken/Fractured Bones
____Bronchitis
____Bruises easily
____Bursitis
____Cancer
____Carpal Tunnel
____Celiac Disease
____Chronic Fatigue
____Cold Sores
____COPD
____Congestive Heart Failure
____Constipation
____ Crohn's Disease
____ COVID-19
____Currently Pregnant
____Depression
____Diabetes
____Diverticulitis/ Diverticulosis
____Dizziness
____Earaches
____Ear Tubes
____Eczema
____Edema
____Emphysema
____Endometriosis
____Epilepsy
____Eye Strain/Pain
____Fainting
____Fibromyalgia
____Foot Pain
____Gas/bloating
____Gout
____Headaches
____Head Injury
____Heart Attack
____Heart Palpations
____Hepatitis
____Hernia
____Herniated Disk
____Herpes
____Hip Pain
____HIV
____Insomnia
____IBS
____IUD
____Jaw Pain
____Joint Pain
____Kidney Stones
____Knee Pain
____Leg Pain
____Low Back Pain
____Lyme Disease
____Lymph Nodes
____Enlarged
____Removed
____MASA
____Major Scars
____Mid Back Pain
____Migraine Headache
____Mold Illness
____Multiple Sclerosis
____Muscle Pain
____Nausea
____Neck Pain
____Night Sweats
____Numbness/ Tingling
____Neuropathy
____Open Wounds
____Osteoporosis/ Osteoarthritis
____Pinched Nerve
____Pneumonia
____Polio
____POTS
____Psoriasis
____Psychiatric Care
____Radiation
____Rash
____Rheumatoid Arthritis
____Sciatica
____Seizures
____Scoliosis
____Shoulder Pain
____Sinus Issues
____SIBO
____Sleep Disorders
____Spasms
____STD's
____Strains/Sprains
____Stress
____Stroke
____Surgical Implants
____Swelling of the Legs/Arms
____Tendonitis
____TOS
____Thyroid Issues
____Tinnitus
____ Tonsillitis
____Tuberculosis
____Tumors/Growths
____TMJ
____Ulcerative Colitis
____Ulcers
____Upper Back Pain
____UTI
____Varicose Veins

Is there anything else that your therapist should know 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: It is important that you complete this intake in full. **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.

Initial: _____ **Columbia Lymphatic Massage reserves the right to refuse, postpone or terminate treatment whenever we deem it in the best interest of one or more of the parties.**

Initial: _____ **Release of Records/Permission to Communicate Consent:** I hereby give Columbia Lymphatic Massage consent to communicate with any and all practitioners involved in my treatment as they deem necessary.

Initial: _____ **Cancellation Policy**: I agree to pay the full fee of the service missed if I do not give a 48 hour notice of cancellation or if I do not show for an appointment.

Initial: _____ **Minors:** Parents must accompany any minor under 18 years of age to each and every appointment.

Client Signature: _____ Date _____

Practitioner Signature: _____ Date _____