Lymphatic Drainage Intake Form

Health Information Contact Information

Client Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

D.O.B.: _____ Gender & Preferred pronouns: _____

Emergency contact: _____ Phone: _____

Physician/Healthcare provider name: _____ Phone: _____

Have you ever received lymphatic drainage therapy before? Yes ☐ No ☐ How recently? _____

Have you ever received Zero Balancing before? Yes ☐ No ☐ How recently? _____

Have you ever received massage therapy before? Yes ☐ No ☐ How recently? _____

What types of bodywork do you prefer? _____

What are your goals/expected outcomes for receiving massage/bodywork?

_____

_____

_____

How do you feel today? _____

_____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

_____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No
Explain:

_____

_____

List the medications you currently take:

_____

_____

Can you rate/describe your regular stress level? _____

_____

Are you pregnant? Yes ☐ No ☐

Health History

Have you had any injuries or surgeries in the past? They may influence today's treatment.

_____

_____

Have you ever received radiation treatment or had lymph nodes dissected or removed?

_____

_____

Please answer honestly, as lymphatic drainage therapy, Zero Balancing or other bodywork may not be indicated for the above conditions. Please indicate conditions that you **have or have had** in the past. Explain if needed.

Current Acute infection/inflammatory illness in development _____

Current Past Chonic infection/inflammation _____

Current Past Muscle or joint pain/stiffness _____

Current Past Numbness or tingling _____

Current Past Serious circulatory problems (aneurysm, thrombosis, phlebitis, venous obstruction)

_____

Current Past Major cardiac problems_____

Current Past Blood clots/thrombosis/embollism _____

Current Past Edema/Swelling _____

Current Past Bruise easily _____

Current Past Sensitive to touch/pressure _____

Current Past High/low blood pressure _____

Current Past Stroke, heart attack _____

Current Past Varicose veins _____

Current Past Shortness of breath, asthma _____

Current Past Cancer _____

Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____

Current Past Epilepsy, seizures _____

Current Past Headaches, Migraines _____

Current Past Dizziness, ringing in the ears _____

Current Past Digestive conditions (e.g. Crohn's, IBS) _____

Current Past Gas, bloating, constipation _____

Current Past Kidney disease, infection, urinary issues _____

Current Past Arthritis (rheumatoid, osteoarthritis) _____

Current Past Osteoporosis, degenerative spine/disk _____

Current Past Scoliosis _____

Current Past Broken bones _____

Current Past Allergies _____

Current Past Diabetes _____ _____

Current Past Endocrine/thyroid conditions _____

Current Past Depression, anxiety _____

Current Past Memory loss, confusion, easily overwhelmed _____

Current Past Fibromyalgia _____

Current Past (acute) Anuresis _____

Current Past HIV infection _____

Current Past Major kidney problems _____

Current Past Removed spleen _____

Current Past Skin conditions _____

Comments:

_____

_____

Consent for Treatment

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 professional bodywork including massage therapy, lymphatic drainage therapy and Zero Balancing 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.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent/Guardian Signature (minor): _____ Date: _____