LYMPHATIC MASSAGE INTAKE

Name: _____ Phone: _____

E-Mail Address: _____

Physical Address: _____ Zip: _____

Date of Birth: _____ How did you hear about us?_____

Emergency Contact: _____ Relation: _____ Phone: _____

Manual Lymphatic Drainage (MLD) is a gentle treatment to speed up the movement of lymph fluid to relieve pain and swelling, assist the body's own healing processes, boost immunity, and reduce the chance of scar formation. The pressure used during this session is extremely light (the pressure of the weight of a nickel.) If deeper pressure is used, the session will not be as effective with its results and could exacerbate the condition. Thank you for understanding.

Are you pregnant? ❑ Yes ❑ No If yes, what trimester? _____ Current athletic ability: ❑ Poor ❑ Average ❑ Good

Which service(s) have you experienced? ❑ Massage ❑ Acupuncture ❑ Yoga ❑ Reiki ❑ Other _____

Have you been involved in an accident, had surgery, or been hospitalized in the last 3 years? ❑ Yes ❑ No

List any chronic conditions that you deal with on a regular basis: _____

Are you taking any medications or herbs? ❑ No ❑ Yes (specify) _____

Do you have any allergies (especially to nuts)? ❑ No ❑ Yes (specify) _____

Have you had Manual Lymphatic Drainage Therapy (MLD) ❑ Yes ❑ No

Name of therapist/spa/office where you have had these sessions _____

For what reason are you seeking Manual Lymphatic Drainage? ❑ Medical Reason ❑ Relaxation

If medical reason, please explain?

_____

Physician/Surgeon Contact Name _____ Phone _____

Have you already received Manual Lymphatic Drainage after surgery? ❑ Yes ❑ No How many sessions? _____

During your massage, are you **unable** to lie on your ❑ Stomach ❑ Back ❑ Side?

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PLEASE MARK ALL SURGERIES AND DATES

COSMETIC SURGERIES			OTHER
LIPOSUCTION ❑ 360 _____ ❑ Abdomen _____ ❑ Waist/Flanks _____ ❑ Arms _____ ❑ Hips _____ ❑ Thighs _____ ❑ Back _____ ❑ Neck _____	BREAST ❑ Augmentation _____ ❑ Removal _____ ❑ Lift _____ OTHER ❑ Abdominoplasty (Tummy Tuck) _____ ❑ Brazilian Butt Lift (BBL) _____ ❑ Hip Augmentation _____	❑ Neck _____ ❑ Shoulder _____ ❑ Knee _____ ❑ Leg _____ ❑ Hip _____ ❑ Back _____ ❑ Foot _____	

PLEASE MARK ALL CURRENT AND PREVIOUS CONDITIONS THAT APPLY TO YOU

GENERAL
❑ Fever
❑ Arteriosclerosis
❑ Carotid Sinus Issues
❑ Hyperthyroidism
❑ Liver Cirrhosis

EARS, NOSE, THROAT
❑ Ringing in Ears
❑ Sinus Problems
❑ Earaches

FEMALE REPRODUCTIVE
❑ Currently Pregnant
❑ Currently Menstruating
❑ Fibrocystic Breast Disease
❑ IUD

NEUROLOGICAL
❑ Strokes
❑ Seizures

MUSCULOSKELETAL
❑ Osteoporosis
❑ Osteoarthritis
❑ Hernia
❑ Rheumatoid Arthritis
❑ Other

CARDIOVASCULAR
❑ Chest pain or pressure
❑ Swelling of legs
❑ Palpitations
❑ Varicose Veins
❑ Dizziness
❑ Acute Deep Vein Thrombosis
❑ Congestive Heart Failure
❑ Heart Attack
❑ High/Low Blood Pressure
❑ Aneurysm
❑ Cardiac Arrhythmia
❑ Other

GASTRO - INTESTINAL
❑ Crohn's Disease
❑ Abdominal Pain
❑ Surgical Implant (mesh or other)
❑ GI Inflammation
❑ Diverticulitis/Diverticulosis
❑ Other

URINARY
❑ Kidney Failure
❑ Kidney Stones
❑ Urinary Tract Infection
❑ Dialysis
❑ Other

SKIN
❑ Cellulitis
❑ Rash
❑ Major Scars
❑ Lumps
❑ Other

HEMATOLOGIC/LYMPHATIC
❑ Cuts that do not stop bleeding
❑ Enlarged Lymph Nodes/Glands
❑ Lymph Nodes Removed
❑ Frequent Bruising
❑ HIV/AIDS
❑ Other

ALLERGIES
❑ Ear Fullness
❑ Sinus Congestion
❑ Recent Sinus Surgery
❑ Other

EMOTIONAL
❑ Stress
❑ Anxiety
❑ Difficulty Sleeping
❑ Depression
❑ Other

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FOR CANCER FIGHTERS

Are you currently undergoing cancer treatments? ❑ Yes ❑ No

- If yes, do you have written permission from your treatment team to receive Manual Lymphatic Drainage at this time? ❑ Yes ❑ No
- If no, what was the date of your last treatment? _____

Type of cancer and location _____

Date of diagnosis _____

Are you experiencing any pain? If yes, where? _____

Have you had lymph nodes removed? ❑ Yes ❑ No If yes, from where?_____

Number of nodes removed _____

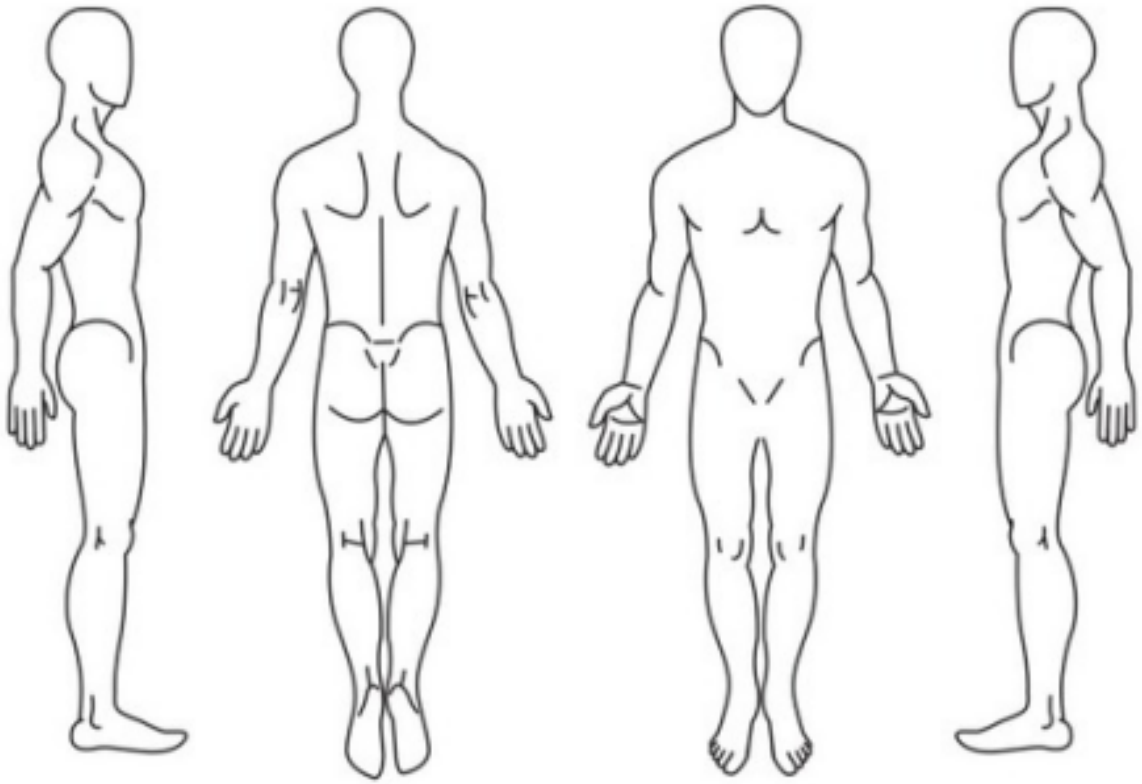
Cancer Related Surgery*	❑ Yes ❑ No ❑ Ongoing	Completion Date _____
Reconstruction	❑ Yes ❑ No ❑ Ongoing	Completion Date _____
Chemotherapy	❑ Yes ❑ No ❑ Ongoing	Completion Date _____
Radiation	❑ Yes ❑ No ❑ Ongoing	Completion Date _____

- List surgeries here:

_____

_____

MARK PAINFUL OR DISTRESSED AREAS



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Agreement of Release and Waiver of Liability (*please read and sign)*

I understand that the Manual Lymphatic Drainage (MLD) 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 my session. I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

Manual Lymphatic Drainage is a very powerful modality and certain medical conditions are contradicted 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.

I understand that canceled or missed appointments without 24-hour notice (medical emergencies excluded) may be charged in full for the price of missed session.

I understand the service(s) I am receiving may be contraindicated for specific medical conditions and symptoms. I further understand the services are not substitutes for medical care and that therapists for these services do not diagnose disease, prescribe medicine or manipulate bones. If at any time during the service I feel uncomfortable, I may end the session. I take responsibility for alerting my therapist or instructor to any changes that occur with my health.

I understand that draping of the breast will be used at all times for female clients during each session for massage and cupping, and therapists will not massage the breasts without written consent. I understand that draping of the genital area and gluteal cleavage will be used at all times for all clients during each session for massage and cupping.

Therapist will immediately end the session if a client initiates any verbal or physical contact that is sexual in nature.

I knowingly, voluntarily, and expressly waive any claim I may have against Sana Vida, its owners, employees or therapists for injury or damages that I may sustain as a result of my participation. I, my heirs or legal representatives forever release, waive, discharge and covenant not to litigate Sana Vida, its owners, employees or therapists for any injury or death caused by their negligence or other acts.

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Client signature: _____ Date: _____

If under 17 years, signature of legal guardian: _____ Date: _____

Therapist's signature (if applicable): _____ Date: _____