THE DIVAS CARE LLC.

Lymphatic Massage Intake Form

Please keep this page for your records

Lymphatic Massage Intake Form

Personal Health History: Please write down past or current symptoms for each category High blood pressure HIV/AIDS Infection Kidney infections/stones Liver Disease Low Blood pressure Lung Disease Migraine Headaches Major organ failure Major scars Musculoskeletal Nausea Neurologic Issues Neuropathy Pneumonia Pregnancy Sinus congestion or problems Skin issues Stroke Surgery Swelling Tinnitus Thyroid Disorder/disease Transient Ischemic Attack Weight gain Other: Abdominal pain Allergies Arthritis Aneurysm Autoimmune disorder Bowel problems Blood clots Broken bones Bruise Easily Cancer: Cardiovascular problem: Chronic Bronchitis Chronic Constipation Chronic Ear infections Congestive Heart Failure Clotting Deep vein thrombosis Depression/Anxiety Diabetes Enlarged lymph nodes Fatigue fever Fibrocystic Breast Gastrointestinal Issues Heart Attack Head Injury/Concussion Hematologic/Lymphatic issues Name:

Today's Date: _____ Date of Birth _____ What is the reason you are seeking lymphatic massage today? __ _ _ For Cancer Clients: Are you currently undergoing cancer treatments? _ If yes, do you have written permission from your treatment team, to receive Manual Lymphatic Drainage, at this time? _ If no, what was the date of your last treatment? For Prenatal Clients: Are you still experiencing morning sickness? Have you been told you are a high-risk pregnancy? If Yes, Do you have written permission from your Obstetrician to receive Manual Lymphatic Drainage at this time?

For Medical Referral Clients: Do you give your therapist permission to consult with your referring provider your protected health information for the purpose of this visit? No Yes- (Please sign HIPAA Form.) Medications currently taking: Please provide any other information, medical or otherwise, not specified in this intake form that you feel is important for the therapist to know:

*Please note: Manual Lymphatic Drainage (MLD) aka Lymphatic Massage, is a very powerful modality, and certain medical conditions are contraindicated and determine if and when you can receive a session. After 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, or consultation

between your referring provider and lymphatic therapist, before proceeding. Please understand this is for your safety and well-being. I understand that manual lymphatic drainage should not be considered a substitute for medical examination, diagnosis, or treatment, and I should see a physician, or other qualified medical specialists for any mental or physical ailment of which I am aware. I understand that lymphatic therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the sessions should be construed as such. Manual lymphatic drainage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly and to the best of my knowledge. 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.

Client Signature: _____ Date: _____

*Consent to treatment of Minor: By my signature below, I hereby authorize the certified manual lymphatic drainage therapist, to administer manual lymphatic drainage to my child or dependent as they deem necessary.

Signature of Parent/Guardian: _____ Date: _____