



## Manual Lymphatic Drainage Intake Form Post-Operative

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

In Case of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Primary Care Physician and Clinic: \_\_\_\_\_

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

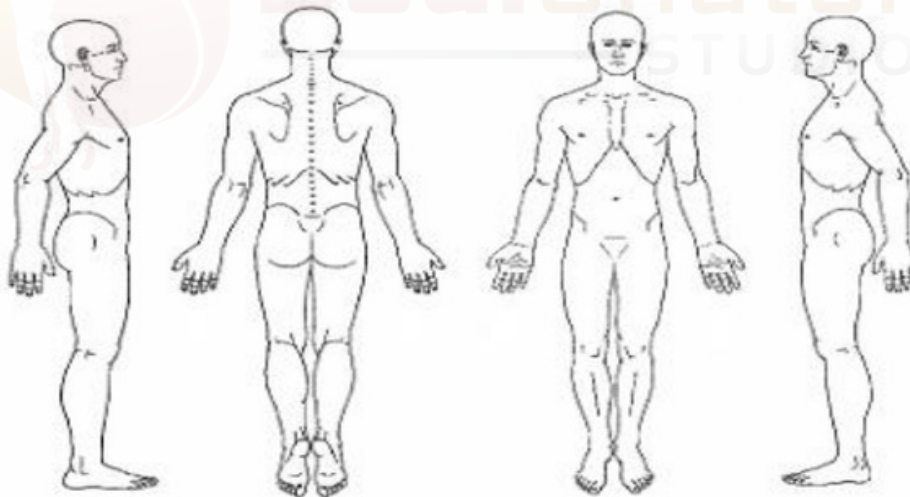
If you are here for a medical issue, when did the problem start?

\_\_\_\_\_

Please describe your problem including where it is and its severity.

\_\_\_\_\_  
\_\_\_\_\_

Please circle all affected areas.



In order to create the most beneficial session, please 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		<b>Musculoskeletal</b>	
Liver Cirrhosis		Osteoporosis	
Other:		Osteoarthritis	
<b>Ears, Nose, Throat</b>		Hernia	
Ringling in ears		Rheumatoid arthritis	
Sinus problems		Other:	
Earaches		<b>Skin</b>	
Other:		Cellulitis	
<b>Cardiovascular</b>		Rash	
Chest pain or pressure		Major scars	
Swelling of legs		Lumps	
Palpitations		Other:	
Varicose veins		<b>Hematologic/ Lymphatic</b>	
Dizziness		Cuts that do not stop bleeding	
Acute deep vein thrombosis		Enlarged lymph nodes (glands)	
Congestive heart failure		Lymph nodes removed	
Heart attack		Frequent bruising	
High/Low blood pressure		HIV/AIDS:	
Aneurysm		Other:	
Cardiac arrhythmia		<b>Neurological</b>	
Other:		Strokes	
<b>Gastro-Intestinal</b>		Seizures	
Crohn's disease		Other:	
Abdominal pain		<b>Allergies</b>	
Surgical implant(mesh or other)		Ear fullness	
GI inflammation		Sinus congestion	
Diverticulitis/Diverticulosis:		Recent sinus surgery	
Other		Other:	
<b>Urinary</b>		<b>Emotional</b>	
Kidney failure		Stress	
Kidney stones		Anxiety	
Urinary tract infection		Difficulty sleeping	
Dialysis		Depression	
Other:		Other:	

**Please list all surgeries (including Cesarean section).**

Surgery	Date	Hospital and Surgeon

**Please list all medications (including vitamins, hormones, and herbs) and reason for prescription.**

Medication	Reason

Is there is anything else that your MLD therapist should know about you or your needs before the session?

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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: Manual Lymphatic Drainage (MLD) is a very powerful modality and certain medical conditions are contraindicated and 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 today. Some conditions will require a note from your doctor before proceeding. Please understand this is for your safety and well-being.

Client Name: \_\_\_\_\_ Date \_\_\_\_\_  
Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent to Treatment of Minor:** By my signature below, I hereby authorize BodiSnatcher Studio LLC to administer Manual Lymphatic Drainage techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Week 2-6 (2-3) times a week**

Lymphatic Massage  
Ultrasound  
Presso therapy  
Infrared Blanket  
Infrared light

**Week 6-8**

Lymphatic Massage  
Radio Frequency  
Wood Therapy (Small / Big Tools)  
Micro Current (EMS)  
Pesso Therapy

**Week 8 +**

Lymphatic Massage  
Presso Therapy  
Vacuum Therapy  
Cavitation (If Needed)  
Wood Therapy (Small / Big Tools)

The logo for BodiSnatcher Studio LLC features the company name in a large, light-colored, sans-serif font. Below the name, the words "STUDIO LLC" are written in a smaller, all-caps font. A horizontal line is positioned between the main name and the subtitle. To the left of the text is a faint, stylized graphic of a human figure with an arrow pointing upwards, suggesting movement or health.