DETOX Lymphatic Massage Intake

First Name: _____ Last Name: _____ Date of Birth:_____

Have you ever received Manual Lymphatic Drainage (MLD)? □ NO □ YES If so, when? _____

For Clients with History of Cancer □ N/A
(if not applicable please indicate so and skip to next section)

What was your diagnosis? Type and Stage _____

Are you in remission? □ YES □ NO Date of last treatment : _____

Have you had chemotherapy? □ YES □ NO Radiation? □ YES □ NO Adjuvant therapies? _____
(For example, hormone or targeted therapy)

Have you had surgery? □ YES □ NO If so, where? _____ Have lymph nodes been removed? □ YES □ NO

If so, where? _____ How many? _____Do you notice swelling? □ YES □ NO

If you are currently receiving treatment, how often? _____
Do you have written permission from your healthcare provider to receive MLD (Manual Lymphatic Drainage); □ YES □ NO

For Clients who have received Surgical Procedures □ N/A
(if not applicable please indicate so and skip to next section)

Did your surgeon recommend post-surgical MLD? □ YES □ NO Date of surgery? _____

If so, have you already received MLD after this surgery? □ YES □ NO If so, when? _____ # of Sessions? _____

Are you experiencing pain, swelling, or bruising? **Circle all that apply** If so, where? _____

Are you noticing thickening of the tissue (fibrosis)? □ YES □ NO Numbness? □ YES □ NO Please indicate below all surgeries;

Liposuction: □ 360 (around entire waist, abdomen, back) □ Abdomen □ Ankles □ Arms □ Back □ Buttocks
□ Chin □ Hips □ Knees □ Neck □ Thighs □ Waist and flanks

Body Lifts : ___ Abdominoplasty (Tummy Tuck) ___ Arm Lift ___ Body Contouring (Skin Removal) ___ Thigh Lift

___ Buttock Enhancement (Brazilian Butt Lift - BBL) ___ Mommy Makeover (please ensure you check all procedures included)

Face & Neck : ___ Brow Lift ___ Cheek Augmentation ___ Cheek Reduction ___ Chin ___ Ear ___ Eyelid ___ Face Lift ___ Facial Implants ___ Neck Lift ___ Rhinoplasty ___ Thread Lift

Nonsurgical Fat Reduction : ___ Cryolipolysis (CoolSculpt) ___ Injection lipolysis (Kybella) ___ Laser lipolysis (SculpSure)

___ Radiofrequency lipolysis (Vanquish)

Gender Affirmation Surgery (□ Transfeminine □ Transmasculine); □ Facial □ Top □ Bottom

Breast: □ Areola □ Augmentation (____Fat Transfer or ____Implants; □ saline or □ silicone) □ Breast Lift □ Expander

□ Implant Removal □ Implant Revision □ Reduction **.....continued on reverse.....**

Do you have issues with blood clots or clotting? □ No □ YES Are you wearing compression garments? □ NO □ YES

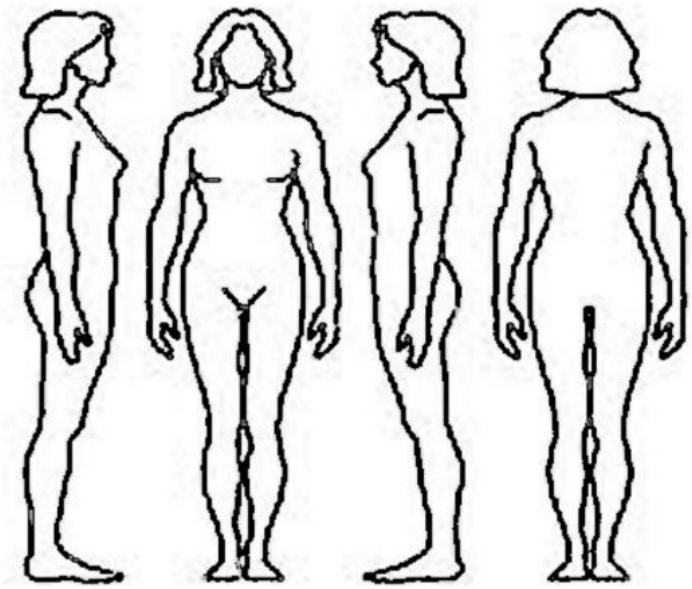
Were drains used following the procedure? □ NO □ YES, Where: _____

Do you still have drains in place? □ NO □ YES, How many? _____

Please provide any additional details of your recent surgery (clinic, city and state, surgeons name, complications and recovery):

_____

Please mark all areas that apply to your sur-



Please list ALL medications and the reason for taking them;

Medication:	Reason:	Related to Surgery?
_____		☐ YES ☐ NO
_____		☐ YES ☐ NO
_____		☐ YES ☐ NO
_____		☐ YES ☐ NO
_____		☐ YES ☐ NO

Prior Surgeries and Treatments (include years):_____

_____

Falls and Injuries (include years): _____

_____

Pregnancies (include years):_____

I understand that the Manual Lymphatic Drainage (MLD) I receive is provided for the basic purpose of lymphatic drainage and movement. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the treatment, pressure and/or strokes may be adjusted to my level of comfort. I further understand that MLD should not be construed as a substitute for medical examination, diagnosis, or treatment and that I see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that MLD certified 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 MLD 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature: _____ Date: _____