# *MASSAGE THERAPY & LYMPHATIC DRAINAGE ~ NEW PATIENT INTAKE*

**Personal Information:**

Name_____ Phone _____ Email_____

Address_____ City/State/Zip_____ DOB_____

Emergency Contact_____ Relationship_____ Phone _____

Occupation_____ Employer_____ Primary Physician_____

How did you hear about us/whom may we thank for your referral?_____

Treatment sought: Rehabilitative Massage / Relaxation Massage / Manual Lymphatic Drainage / Unsure

Primary reason for consultation/treatment:_____

Receiving other therapies for this reason? Y / N If yes, what?_____

**Health & Medical History:**

How would you rate your overall health? excellent / very good / good / fair / poor

What are your overall health and wellness goals? _____

How would you rate your energy level? good / poor / erratic / fatigued / other_____

Do you feel you get adequate sleep? Y / N If not, what prevents you from doing so? _____

Do you participate in physical activity? Y / N If yes, how often and what? _____

Do you smoke? Y / N Commonly around people that smoke? Y / N

Current medications (including supplements & nonprescription): _____

Please list any surgeries, with dates: _____

Currently undergoing, or recent cancer treatment? Y / N If yes, date of last chemotherapy: _____

Women: Currently pregnant? Y / N Recently pregnant? Y / N First day of last menstrual period? _____

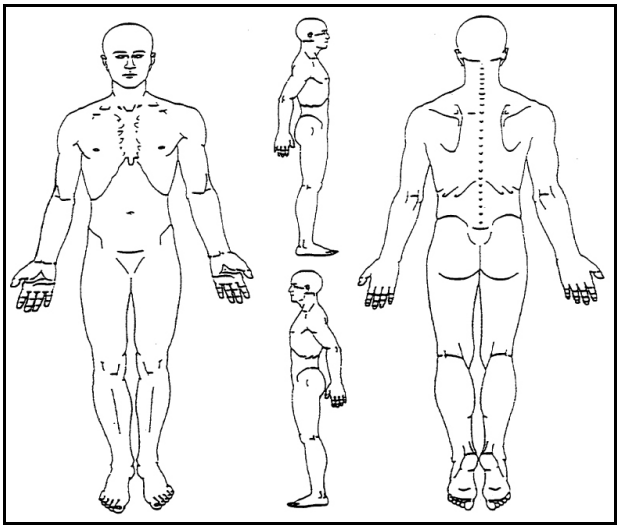
History of any of the following:

| | | | | | |
|---|---|---|---|---|---|
| | Allergies / Sensitivities | | Depression, Anxiety | | Lyme / Borrelia |
| | Aneurysm, type: | | Diabetes | | Meningitis |
| | Asthma | | Diverticulosis, Diverticulitis | | Osteoporosis |
| | Arthritis, Joint Problems | | Dizziness | | Phlebitis |
| | Arrhythmia | | Fibroids, Cysts | | Pneumonia / Lung Disease |
| | Arteriosclerosis | | Gastrointestinal Issues | | Radiation Fibrosis, Colitis, Cystitis |
| | Back Pain | | Headaches, type: | | Rashes (frequent) |
| | Broken Bones | | Heart Concerns, Heart Attack | | Rheumatic Fever |
| | Cancer, type: | | Hernia, type: | | Seizures / Epilepsy |
| | Cellulitis | | High Blood Pressure | | Stroke |
| | Circulatory Concerns | | HIV/AIDS | | Swelling |
| | Cirrhosis | | Implanted Device, type: | | Thyroid, type: |
| | Crohn's Disease | | Kidney Infections, Stones | | Tuberculosis |
| | Deep Vein Thrombosis | | Liver Disease | | Varicose Veins |
| | | | | | |

# *MASSAGE THERAPY & LYMPHATIC DRAINAGE ~ NEW PATIENT INTAKE*

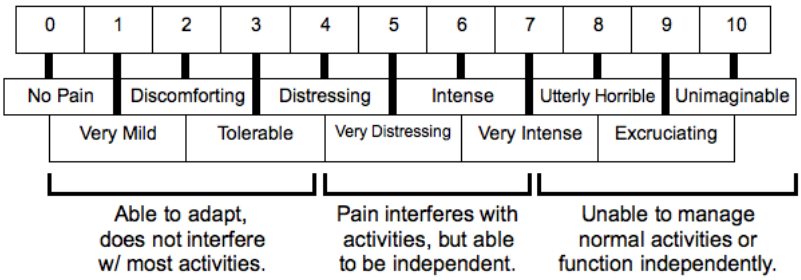
**Current Concerns:**

Pain/Symptom Location(s):



Pain/Symptom Frequency:_____% of the time.

Pain/Symptom Intensity (at worst): _____ / 10.




Are symptoms related to any known accident or trauma? Y / N

If yes, what and when? _____

What makes symptoms better? _____ Makes them worse? _____

Additional information you feel is important for your therapist to know:_____

_____

Symptoms Review (*to be completed with your therapist*):

| | |
|---|---|
| Circulatory | |
| Gastrointestinal/Digestive | |
| Lymphatic | |
| Musculo-Skeletal | |
| Nervous | |
| Reproductive | |
| Respiratory | |
| Skin | |
| Urinary | |
| | |
| | |

**Please read and initial the following:**

_____ • Evaluation: I acknowledgement that my first appointment will consist of approximately 15 minutes of discussion, evaluation, and recommendations, and approximately 45 minutes of hands-on therapy.

_____ • Manual Lymphatic Drainage (MLD): I acknowledge that MLD is not suitable for everyone, and that after reviewing my medical information, the therapist will determine if I am eligible. I further acknowledge that some conditions will require a Doctor's note prior to treatment.

• Draping: I acknowledge that Washington State Law requires that the breast/chest area remain covered, unless there is prior, informed verbal and written consent, and I indicate the following:

_____ I *consent* to have my chest/breasts temporarily undraped, as is necessary to complete my treatment.

_____ I *do not* consent to have my chest/breasts undraped at any time.

*I have completed this form to the best of my ability and knowledge. I agree to inform the practitioner of all changes to my medical information, and understand that there shall be no liability on the practitioner's part should I fail to do so.*

Client Signature: _____ Printed Name: _____ Date:_____

Therapist Signature: _____ Printed Name: _____ Date:_____