Feeling Great
Therapeutic & Lymphatic Massage

MLD Intake Form

370 Maple Ave. W Suite 2
Vienna, VA 22180
(703)663-8600

Personal Information

Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____) _____ Email: _____
Occupation: _____
Emergency Contact: _____ Phone: (_____) _____

Referred by/How did you hear about us?
_____

May we send you special offers via email?
☐ Yes ☐ No

For what reason are you seeking Manual Lymphatic Drainage (MLD)?
___ Post-Surgical ___ Swelling ___ Detox/Immunity

The following information will be used to plan a safe and effective massage session.
Please answer the questions to the best of your knowledge.

For cancer patients:
Are you currently undergoing cancer treatments? ___ Yes ___ No

- Do you have permission from your treatment team to receive MLD at this time? ___ Yes ___ No
- What was the date of your last treatment: Chemo? _____ Radiation? _____
- Did you have lymph nodes removed? ___ Yes, how many? _____ ___ No

If you are here for a medical issue, please explain the problem: _____
_____
_____

Have you been diagnosed with Lymphedema? ____ Yes ____ No
If so, how long ago? _____ Circle Area: R / L Legs R / L Arms Other _____
Have you received surgery in the last 6 months? ___ Yes ___ No
If so, have you received MLD after surgery? ___ Yes ___ No How many sessions? _____

Please mark ALL surgeries/procedures for your safety

Common Cosmetic & Reconstructive Surgeries		Common Orthopedic Surgeries	Other
☐ Liposuction: ☐ 360 ☐ Abdomen ☐ Waist/Flanks ☐ Back ☐ Hips ☐ Thighs ☐ Arms ☐ Chin ☐ Chest ☐ Face Lift ☐ Rhinoplasty	☐ Breast ☐ Augmentation ☐ Removal / Reduction ☐ Lift ☐ Skin Removal ☐ Tummy Tuck ☐ Tummy Tuck with Muscle Repair ☐ DIEP Flap ☐ Fat Transfer ☐ Breast ☐ Buttocks (BBL) ☐ Hips ☐ Face	☐ C-section ☐ Sinus ☐ Neck ☐ Shoulder ☐ Arm ☐ Leg ☐ Knee ☐ Foot ☐ Back ☐ Hip	_____ _____ _____ _____ _____ _____ _____

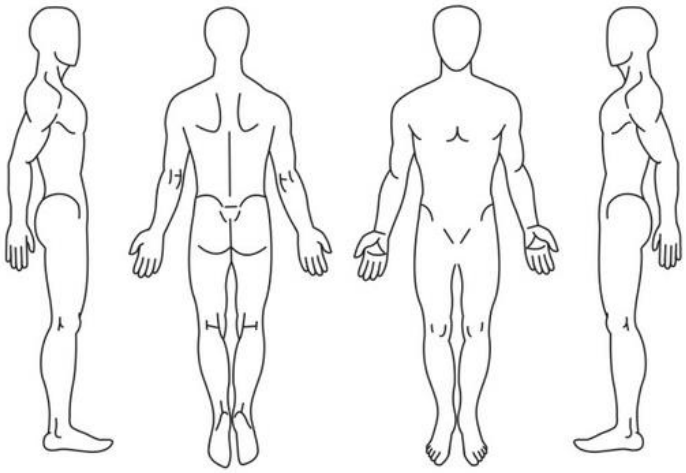
Surgery Date	Procedure & Hospital / Clinic	Surgeon

Please mark ALL current and previous conditions that apply.

General	
Fever (currently)	
Arteriosclerosis	
Carotid sinus issues	
Hyperthyroidism	
Liver Cirrhosis	
Other:	
Ears, Nose, Throat	
Ringing in ears	
Sinus problems	
Earaches	
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:	

Female Reproductive	
Currently Pregnant / Recently gave birth	
Currently menstruating	
Fibrocystic breast disease	
IUD	
Other:	
Musculoskeletal	
Osteoporosis	
Osteoarthritis	
Hernia	
Rheumatoid arthritis	
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:	
Neurological	
Strokes	
Seizures	
Other:	
Allergies	
Ear fullness	
Sinus congestion	
Allergic to:	
Other:	
Emotional	
Stress	
Anxiety	
Difficulty sleeping	
Depression	
Other:	

Please use the diagram to circle problem area:



Are you currently taking medications? If so, please list reason for prescription:

_____

_____

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

_____

_____

_____

_____

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 Manual Lymphatic Drainage may cause reactions in some people, such as headache, nausea, light-headedness, fatigue and on rare cases vomiting. These reactions, although normal, may last a couple of days after treatment but should dissipate. For this reason, I understand I need to drink plenty of water for the next 48-hours following treatment to keep my body extra hydrated. If these reactions continue past the two days, please contact your healthcare provider for further assistance.

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 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.*

Client Signature: _____ Date _____

Practitioner Signature: _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Feeling Great, LLC, to administer Manual Lymphatic Drainage techniques to my child or dependent as they deem necessary.
Signature of Parent or Guardian _____ Date _____