wildflower

LYMPHATIC THERAPY

INTAKE AND CONSENT FORM

The information you provide below will assist the therapist in treating you safely and will be kept confidential unless allowed or required by law.

Contact and Personal Information

Name: (please print) ____

Date: ______________________ Address: ____

City: ________________________ Postal Code: ______________________

Phone: (Home) _________________________ (Cell) ____________________

Email: _____________________________________

Birthday (dd/mm/yy) _____________________ Occupation: _________________________________

Reason for visit: ____

Emergency Contact: _____________________________ Phone: _____________________

Family Doctor: _________________________ Were you referred by anyone? _____________________

Health History

Have you had a manual lymph drainage treatment before? ○ Yes ○ No

If yes, how often do you receive a treatment? _____________________

Do you see any other health care practitioners?

☐ Medical ☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist

Other ____

Reason for seeking manual lymph drainage therapy? ☐ Maintenance ☐ Injury ☐ Condition

Other concerns: ____

Do you have difficulty lying on your: ☐ Back ☐ Front ☐ Side

Are you on any medications or supplements? ○ Yes ○ No

If yes, please list and explain for what condition(s):

____

____

Surgeries (including caesarean section)/injuries? (Date, past & current symptoms)

____

____

List any medical implants Pacemaker/Pins/Wires/Artificial Joints/special equipment

____

Please indicate if you presently or previously had any of the following symptoms or ailments:

General:

☐ Fever ☐ Undergoing cancer treatments ☐ Last chemotherapy session ☐ 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 blood pressure
☐ Low blood pressure ☐ Aneurysm ☐ Cardiac arrhythmia

Other: ______________________________

Gastro-Intestinal:

☐ Crohn's ☐ 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 ☐ Currently menstruating ☐ Fibrocystic breast disease ☐ IUD

Other: ______________________________

Musculoskeletal:

☐ Osteoporosis ☐ Osteoarthritis ☐ Hernia ☐ Rheumatoid arthritis

Other: ______________________________

Skin:

☐ Cellulitis (bacterial skin infection) ☐ 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 ☐ Recent sinus surgery

Other: ________________________________

Emotional:

☐ Stress ☐ Anxiety ☐ Difficulty sleeping ☐ Depression

Other: ________________________________

Describe any other diagnosed diseases, medical conditions or health concerns your MLD therapist should be aware of:

____

____

Wildflower Lymphatic Therapy Informed Consent

I have informed the MLD therapist of all my known physical/medical conditions and medications. I will keep the MLD therapist updated on any changes to my health history.

I understand;

- Why a health history is needed before a treatment begins.
- That I may ask questions about the information being requested and my therapy at anytime.
- That all client information is confidential and written authorization will be obtained prior to release of information to other caregivers.
- The general benefits of the therapy treatment, possible therapy contraindications and precautions.
- The assessment and treatment procedures, and techniques employed to the body areas being treated.
- That draping will be used to expose only those areas that require treatment.
- That at any time, I may withdraw my consent and treatment will be stopped.
- The duration and cost of the MLD therapy treatment.
- That MLD therapy is not a substitute for medical treatment or medications.
- That it is recommended that I work with my Primary Caregiver for any condition I may have.
- That a MLD therapist does not diagnose illness or disease and does not prescribe medications.

I ____ , (print) have read, understood and completed to the best of my knowledge, the Wildflower Lymphatic Therapy Client History form and the Wildflower Lymphatic Therapy Informed Consent form. I release the MLD Therapist from any and all liability form problems arising from the treatment as a result of information not given or incorrectly given in this client history form.

Client/Guardian Signature: ________________________________ Date: ____________________

Practitioner Signature: ____________________________________ Date: ____________________