Esbelta BODY

Date

Post Op Manual Lymphatic Drainage Intake

Name | DOB | AGE

Address

Phone | Occupation

Email

Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy? _____

Do you have any allergies to topical oils, lotions or ointments? Yes No

If yes, please list _____

Did you post-op team or surgeon recommend post-op MLD massage? Yes No

If no, how did you know to seek post-op MLD massage? _____

What procedure/surgeries did you have?

- ☐ Liposuction
- ☐ BBL
- ☐ Facelift
- ☐ Eye/Brow Lift
- ☐ Abdominoplasty
- ☐ Chin/Neck Augmentation
- ☐ Breast Augmentation
- ☐ Other

Were drains used following procedure? Yes No

If yes, are drains currently in? Yes No

Are all the incisions healed? Yes No

Has any fluid needed to be removed via needle/syringe? Yes No

What medical instructions are you following for this procedure or your symptoms? Yes No

_____

What post-surgical garments are you wearing? _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes, please explain _____

Are you currently under medical supervision? Yes No

If yes, please explain_____

Do you see a chiropractor? Yes No

If yes, how often? _____

Are you currently taking any medications? Yes No

If yes, please list _____

Medical History

Please check off and circle any conditions that you currently or have previously experienced.

SKIN

- [ ] Rashes
- [ ] Eczema
- [ ] Psoriasis
- [ ] Acne
- [ ] Herpes
- [ ] Cold Sores
- [ ] Fungal Infection
- [ ] Athletes Foot
- [ ] Warts
- [ ] Boils
- [ ] Impetigo
- [ ] Lice
- [ ] Skin Cancer

REPRODUCTIVE HEALTH

- [ ] Pregnant
- [ ] Ovarian/Menstrual Problems
- [ ] Prostate

OTHER

- [ ] Cancer/Tumors
- [ ] Bladder/Kidney Ailment
- [ ] Diabetes
- [ ] Chronic Pain
- [ ] Drug Use
- [ ] Alcohol Use
- [ ] Caffeine Use
- [ ] Tobacco Use
- [ ] Stress
- [ ] Other: _____

_____

_____

_____

_____

_____

_____

DIGESTIVE

- [ ] Irritable Bowel Syndrome
- [ ] Ulcerative Colitis
- [ ] Diverticulosis
- [ ] Celiac
- [ ] Chrons
- [ ] Ulcers
- [ ] Cirrhosis
- [ ] Hepatitis
- [ ] Gallstones

NERVOUS SYSTEM

- [ ] Peripheral neuropathy
- [ ] Pinched nerve
- [ ] Numbness
- [ ] Tingling
- [ ] Parkinson disease
- [ ] Tremor
- [ ] Anxiety disorder
- [ ] Depression
- [ ] Eating disorder
- [ ] Headaches
- [ ] Migraines
- [ ] Seizure disorder
- [ ] Sleep disorder
- [ ] Chronic Fatigue syndrome
- [ ] Balance disorder
- [ ] Shingles

MUSCULOSKELETAL

- [ ] Bone or Joint Disease
- [ ] Gout
- [ ] Tendonitis
- [ ] Bursititis
- [ ] Jaw Pain (TMJ)
- [ ] Arthritis
- [ ] Osteoarthritis
- [ ] Rheumatoid arthritis
- [ ] Fibromyalgia
- [ ] Lupus
- [ ] Lyme Disease
- [ ] Osteoporosis
- [ ] Osteopenia
- [ ] Spinal Problems
- [ ] Disc disease
- [ ] Spondylosis
- [ ] Ankylosing Spondylitis
- [ ] Carpel Tunnel
- [ ] Thoracic outlet syndrome
- [ ] Plantar fasciitis
- [ ] Marfan
- [ ] Ehlers-Danlos syndrome

CIRCULATORY/IMMUNE

- [ ] Heart Condition
- [ ] Congestive Heart Failure
- [ ] Phlebitis
- [ ] Varicose Veins
- [ ] Blood Clots
- [ ] Thrombosis (DVT)
- [ ] Embolism
- [ ] High / Low Blood Pressure
- [ ] Lymphedema / Edema
- [ ] HIV/AIDS
- [ ] Fever
- [ ] Lupus

Photo & Video Release Consent

I grant permission to "NAME/COMPANY NAME HERE" to take photographs, videos, or other media for use in marketing, advertising, social media, website, newsletters, magazines, recruiting brochures, emails, books, and general publications. I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please initial below.

_____I am at least 18 years of age and am competent to contract in my own name. I have read this release before signing below, and fully understand the contents, meaning, and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Covid-19 Liability Waiver

Due to the outbreak of the Coronavirus (COVID-19), "NAME/COMPANY NAME HERE" is taking extra precautions to help prevent the spread of this contagious disease. Please read this form entirely. We ask that our clients disclose their health history truthfully and accurately. Please check below if you have any of the following symptoms.

Symptoms of Covid-19 Include:

☐ Fever or Chills	☐ Nausea or Vomiting	☐ Sore Throat	☐ Fatigue
☐ Headache	☐ Muscle or Body Aches	☐ Congestion/Runny Nose	☐ Cough
☐ Diarrhea	☐ Loss of taste	☐ Difficulty Breathing	☐ None

I agree to the following: *Please initial*

1. _____I, and members of my household, have not experienced any of the symptoms listed above within the last 14 days.
2. _____I, and members of my household, have not travelled internationally in the last 30 days.
3. _____I, and members of my household, do not believe we have been exposed to someone with a suspected and/or confirmed case of the Coronavirus (COVID-19).
4. _____I, and members of my household, have not been diagnosed with the Coronavirus (Covid-19) within the last 30 days.
5. _____"NAME/COMPANY NAME HERE" cannot be held liable from an exposure to the Coronavirus (Covid-19) caused by misinformation on this form or the health history provided by each client.
6. _____If I take legal action against "NAME/COMPANY NAME HERE" to make a claim for damages, I shall be obligated to pay all attorney's fees and costs incurred as a result of such claim.

By signing below, you agree to the following:
I understand that the massage I receive is provided for the basic purpose of relaxation, relief of muscular tension and improving the flow of lymph. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapist 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 should be construed as such. I understand that massage 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 my 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