

WELLNESS AESTHETICS

Lymphatic Massage (MLD) Intake Form

Client Information:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Referred By: \_\_\_\_\_

Medical History:

Please check all that apply:

Recent Surgery (last 6 months)  Lymphedema  Cancer (current or past)

Blood Clots/Phlebitis  Autoimmune Disease  Heart/Kidney Conditions

Infections or Fever  Pregnancy  Diabetes

Allergies (list): \_\_\_\_\_

Medications (list): \_\_\_\_\_

Are you currently recovering from surgery?  Yes  No

If yes, what type? \_\_\_\_\_

Date of surgery: \_\_\_\_\_

How many sessions have you had post-op? \_\_\_\_\_

Are you currently wearing compression garments?  Yes  No

Have you experienced:

Swelling  Pain  Stiffness

Fluid retention  Numbness  Drainage tubes

Home Care:

Do you practice dry brushing or rebounding at home?  Yes  No

Cancellation Policy:

All appointments require 36 hours' notice for cancellation or rescheduling. Failure to do so may result in a fee. First missed appointment is forgiven, second missed appointment is subject to a charge. By signing below, you agree to this policy.

Photo Consent:

I give permission for my treatment photos to be used for marketing purposes.

I do not consent to photo use.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_