Holistic Healing Arts

**Petula Jennings, RMO**
**Reg# RMO 01168**

# Manual Lymphatic Drainage Therapy Intake Form

**CONFIDENTIAL CLIENT INFORMATION** Today's Date: ____________

Name: ________________________________________________ Birth Date: _____________

Address: ______________________________________________________________________

Phone: ___________________________ Email: _____________________________________

In Case of Emergency: ____________________________ Phone: ________________________

Name of Primary Care Physician: ____________________________________________

Referred By: _________________________________

**For what reason are you seeking Manual Lymphatic Drainage?** ☐ Therapeutic ☐ Medical Issue
**CHECK ONE**

- If you are here for a medical issue, when did the problem start? ______________________________
- Please describe your problem including where it is and its severity. ____________________________

______________________________________________________________________________

| **Current medications**<br>**(Including hormones, vitamins, herbs, nonprescription medications)** |
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**Personal Past History of Illnesses**

| Major Illnesses | (circle one) | | Major Illnesses | (circle one) | |
|---|---|---|---|---|---|
| Asthma | Yes | No | Collagen Vascular Disease (Lupus) | Yes | No |
| Pneumonia / Lung disease | Yes | No | Bowel Problems | Yes | No |
| Kidney Infections / Stones | Yes | No | Depression / Anxiety | Yes | No |
| Tuberculosis | Yes | No | Seizures / Convulsions / Epilepsy | Yes | No |
| HIV / AIDS | Yes | No | Migraine Headaches | Yes | No |
| Stroke | Yes | No | Diabetes | Yes | No |
| Heart Attack / Problems | Yes | No | Thyroid Disease | Yes | No |
| Aneurysm | Yes | No | Arthritis / Joint / Back Problems | Yes | No |
| High Blood Pressure | Yes | No | Osteoporosis | Yes | No |
| Circulation Problems | Yes | No | Broken Bones | Yes | No |
| Deep Vein Thrombosis | Yes | No | Liver Disease | Yes | No |
| Rheumatic Fever | Yes | No | Cancer (any kind) | Yes | No |
| **Other** | | | | | |

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| Surgical History: | | | |
|---|---|---|---|
| **Operation** | **Date** | **Reason** | **Hospital** |
| | | | |
| | | | |
| | | | |
| | | | |

| Review of Current Symptoms<br>(Check all that apply) | | | |
|---|---|---|---|
| **General** | | **Female Reproductive** | |
| Weight gain | ☐ | Currently Pregnant | ☐ |
| Fever | ☐ | Currently Menstruating | ☐ |
| Fatigue | ☐ | Fibrocystic Breast Disease | ☐ |
| Recent Surgery | ☐ | **Musculoskeletal** | |
| Undergoing Cancer Treatments | ☐ | Osteoporosis | ☐ |
| ** Date of last chemotherapy treatment: | | Arthritis | ☐ |
| **Ears, Nose, Throat** | | **Skin** | |
| Ringing in ears | ☐ | Rash | ☐ |
| Sinus problems | ☐ | Moles | ☐ |
| Earaches | ☐ | Major Scars | ☐ |
| **Cardiovascular** | | Lumps | ☐ |
| Chest pain or pressure | ☐ | **Hematologic / Lymphatic** | |
| Swelling of legs | ☐ | Frequent bruises | ☐ |
| Palpitations | ☐ | Cuts that do not stop bleeding | ☐ |
| Varicose veins | ☐ | Enlarged lymph nodes (glands) | ☐ |
| Dizziness | ☐ | Lymph Nodes Removed | ☐ |
| Acute Deep Vein Thrombosis | ☐ | **Neurologic** | |
| Congestive Heart Failure | ☐ | Dizziness | ☐ |
| Other: | ☐ | Seizures | ☐ |
| **Gastrointestinal** | | **Allergic** | |
| Nausea | ☐ | Ear fullness | ☐ |
| Abdominal pain | ☐ | Itchy eyes | ☐ |
| **Urinary** | | Runny nose | ☐ |
| Urinary Tract Infection | ☐ | Sinus congestion | ☐ |
| Kidney Stones | ☐ | Recent Sinus Surgery | ☐ |

Any information (medical or other) not specified in this intake form that you feel is important for the practitioner to know:

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

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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 Therapy 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 of which I am aware. I understand that the Therapist/ Practitioner is not qualified to perform skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because Manual Lymphatic Drainage Therapy 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 and 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. Your health is important to me.

Client Signature ________________________________________ Date _____________

***Consent to Treatment of Minor:***

By my signature below, I hereby authorize Petula Jennings, RMO, to administer manual lymphatic massage therapy to my child or dependent.

Signature of Parent or Guardian ____________________________________Date ____________

## Email Consent

I hereby give my consent for Holistic Healing Arts to contact me via email on behalf of Petula Jennings, for the purposes of appointment reminders, as well as future activities.

_______________________________

## Private Policy

I hereby authorize my Osteopathic Manual Therapist to release or obtain information pertaining to my medical condition(s) and/or treatment to/from my other healthcare providers or third party. _______________________________

## Financial Policy

Manual Osteopathy is an unregistered profession and as such, some Osteopathic associations will not be recognized by all insurance companies. My Osteopathic association is NOT affiliated with the following: GREAT WEST LIFE, CANADA LIFE, LONDON LIFE, and WRAM.

## Cancellation Policy

Patients are required to provide 24 hours notice for any cancellation of an appointment. The clinic reserves the right to charge the full appointment fee for any cancellations without 24 hours notice.

Date: _____________________ Signature: _________________________________