POST SURGICAL MLD CLIENT INTAKE FORM

Somatic Massage Therapy & Spa®
Therapeutic and Clinical Massage

Today's Date _____

WELCOME! We would like your appointment to be pleasant and comfortable. Please let us know if you have any questions regarding your session.

How did you find us? ◯ Referral ◯ Internet ◯ Email ◯ Gift Certificate ◯ Walk-in ◯ Other _____

Name _____ **Date of Birth** _____

Address _____

City _____ **State** _____ **Zip** _____ **Phone (H)** _____

Email Address _____ **Phone (C)** _____

Occupation _____

Emergency Contact (Name, #) _____

Have you received MLD-massage before ☐ **No** ☐ **Yes** **(If yes, date of last MLD)** _____

Types of massage experienced ◯ Swedish ◯ Therapeutic ◯ Deep Tissue ◯ Hot Stone ◯ MLD ◯ Other _____

Level of pressure your prefer ◯ Light Touch ◯ Moderate ◯ Deep

What are your goals for this session? (What is your reason for seeking MLD - your chief concern?)

_____

_____

_____

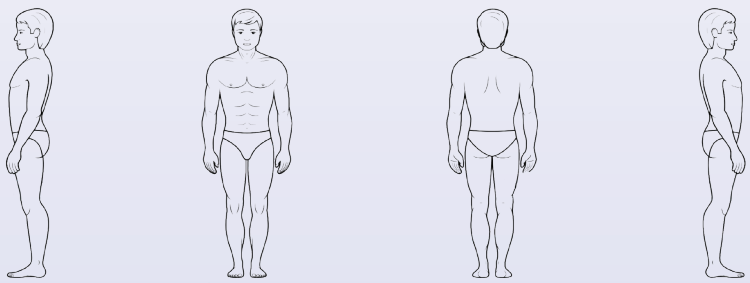
How long have you had these symptoms? _____

What medical instructions are you following for these symptoms? _____

What post-surg. garments have you been wearing? _____

What (if an) positions make vou feel better? _____

Please indicate with an (X) the areas in which you are feeling swelling/bruising/discomfort:



Please list/date all previous surgical procedures (Tummy tuck, BBL, Lipo, Hernia, Breast Augmentation, etc.)

_____

_____

Are you currently taking any medications? ☐ No ☐ Yes (If yes, please list names and reason for medications.)

_____

Are you currently seeing a healthcare professional? ☐ No ☐ Yes (If yes, please list names and reason/treatment)

_____

Please review this list and check those conditions that have affected your health recently or in the past.

Skins

- ◯ Allergies - specify _____
- ◯ Rashes / Eczema / Psoriasis / Acne
- ◯ Herpes / Cold sores
- ◯ Fungal infection / Athlete's foot / Warts
- ◯ Boils / Impetigo / Lice
- ◯ Skin cancer - specify _____

Musculoskeletal

- ◯ Bone or joint disease / Gout
- ◯ Tendonitis / Bursitis / 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
- ◯ Other _____

Respiratory

- ◯ Asthma / Emphysema / Breathing difficulty
- ◯ Cold / Flu / Pneumonia
- ◯ Bronchitis / Sinusitis
- ◯ Allergies - specify _____
- ◯ Lung Cancer
- ◯ Other _____

Circulatory / Immune

- ◯ Heart Condition / Congestive Heart Failure
- ◯ Phlebitis /Varicose Veins
- ◯ Blood Clots/ Thrombosis (DVT)/ Embolism
- ◯ High / Low Blood Pressure
- ◯ Lymphedema / Edema herapeutic and Clini
- ◯ THIV / AIDS ◯ Fever ◯ Lupus

Digestive

- ◯ Irritable Bowel syndrome
- ◯ Ulcerative colitis / Diverticulosis
- ◯ Celiac / Chron's disease
- ◯ Ulcers
- ◯ Cirrhosis / Hepatitis (Liver)
- ◯ Gallstones
- ◯ Other _____

Reproductive

- ◯ Pregnant: # Weeks _____ Trimester _____
- ◯ Ovarian / menstrual problems
- ◯ Prostate - specify _____
- ◯ Other _____

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
- ◯ Other _____

Other

- ◯ Cancer /tumors:
- ◯ Bladder / Kidney ailment
- ◯ Diabetes
- ◯ Chronic Pain
- ◯ Drug use
- ◯ Alcohol use
- ◯ Caffeine / Tobacco use
- ◯ Stress
- ◯ Contact lenses (hard or soft)

Please provide additional details _____

Your signature below indicates that you understand and abide by our Pay in Full, No Show and Late Cancel Policies. A $25 fee will be charged for No Shows and cancellations of less than 24 hrs.

Please read the following information and sign below:
I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork 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/bodywork practitioners 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 given should be construed as such. 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Signature _____ **Date** _____

POST SURGICAL MANUAL LYMPAHTIC DRAINAGE (MLD) INTAKE FORM (all information is confidential)

A few questions about your surgery and previous aftercare experience will assist us in providing you the best possible care.

Last Name | First Name | Today's Date

Date of Surgery _____

Location of Surgery ◯ Miami, Florida ◯ Dominican Replublic ◯ Richmond, VA ◯ Atlanta

◯ New York ◯ Washington, DC ◯ Maryland ◯ Other _____

Surgeon's Name Last Name | First Name | FACILITY/ Surgical Center

On a scale of 1 to 10, how would your rate your surgeon? _____ **Your Post Surgical Care?** _____

Did your surgeon or post op team recommend post surgical massage /MLD? ◯ YES ◯ NO

If no, how did you know to seek post surgical massage/MLD? _____

PROCEDURES? (Please list all)

◯ Liposuction ◯ BBL ◯ J Plasma ◯ Breast Augmentation

◯ Abdominoplasty (Tummy Tuck) ◯ Chin/Neck Augmentation ◯ Cell Saver ◯ Other _____

IF LIPOSUCTION, IN WHAT AREAS?

◯ Abdomen ◯ Arms ◯ Back ◯ Hips

◯ Flanks ◯ Chin ◯ Thighs ◯ Other _____

WERE DRAINS USED FOLLOWING PROCEDURES? ◯ YES ◯ NO

If yes, Are drains currently in? ◯ Yes ◯ No

Are all incisions healed? ◯ Yes ◯ No

HAS ANY FLUID NEEDED TO BE REMOVED WITH NEEDLES/SYRINGES? ◯ **YES** ◯ **NO**

If yes, how often? _____

DID YOU STAY AT A RECOVERY HOUSE? ◯ **NO** ◯ **YES** If yes, for how long? _____

How many massage sessions did you have? _____

WHAT STAGE COMPRESSION GARMET ARE YOU CURRENTLY IN? ◯ **1** ◯ **2** ◯ **3**

ARE YOU CURRENTLY EXPERIENCING PAIN? ◯ **YES** ◯ **NO** If yes, where? _____

ARE YOU CURRENTLY EXPERIENCE SWELLING? ◯ **YES** ◯ **NO** If yes, where? _____

DO YOU NOTICE THICKENED OR FIBROTIC AREAS ANWHERE? ◯ **YES** ◯ **NO** If yes, where? _____

ANY OTHER SYMPTOMS? _____