Health Questionnaire
Manual Lymphatic Drainage Massage Therapy

Name: _______________________________ Birth Date: _____/______/_______

1. What is the reason you are seeking MLD treatment? ____
   ____
2. Do you have lymphedema/edema: ☐ NO ☐ YES, for how long? _________________________________
   Which area(s) of the body has lymphedema? ____
3. Have you had prior treatment for lymphedema/edema? ☐ NO ☐ YES, check all that apply below.
   ☐ Surgery ☐ Antibiotics ☐ Compression garment ☐ Compression pump ☐ Manual Lymph Drainage
4. Please list any medications that you are currently taking _____________________________________
   ____
5. List any injuries or surgeries with dates:____
   ____
   ____
6. Have you ever had any lymph nodes removed? ☐ NO ☐ YES, from what area (s)? __________________
   ____
7. Physician's Name: ____________________________________ Phone # ___________________
   May we contact your physician regarding your treatment? ☐ YES ☐ NO

Do you currently (C) have or have had a history (H) of the following?

C | H
☐ ☐ Infections
☐ ☐ Radiation Therapy
☐ ☐ Chemotherapy
☐ ☐ Hypertension
☐ ☐ Circulatory Problems/Blood Clotting Issues
☐ ☐ Stroke/Anyeurisms
☐ ☐ Cardiac Problems
☐ ☐ Diabetes
☐ ☐ Digestive Disorders

C | H
☐ ☐ Skin Conditions/Open Wounds/Bruises
☐ ☐ Thyroid Dysfunctions
☐ ☐ Pregnancy / Menstrual Issues
☐ ☐ Fibromyalgia
☐ ☐ Chronic Fatigue Syndrome
☐ ☐ Sinus Problems
☐ ☐ Headaches
☐ ☐ RSD
☐ ☐ Bronchial Asthma
☐ ☐ Allergies

I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on changes in my physical health. By signing below I am consenting to treatment and acknowledge that MLD may take several treatments to see results. I agree to give 24 hours notice before cancelling appointments.

Signature: _____________________________________ Date: __________________________

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