

**Manual Lymphatic Drainage Therapy**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

In case of Emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If no referral, how did you hear about us: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what reason are you seeing Manual Lymphatic Drainage? (Note: if there is a question you do not feel comfortable answering, you can leave it blank, and we will go over it in the visit if necessary.)

CHECK ONE: \_\_\_\_\_ Therapeutic \_\_\_\_\_ Medical Issue

If you are here for a medical issue, when did the problem start? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your problem including where it is and its severity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently undergoing cancer treatments: \_\_\_\_Yes \_\_\_\_ No

If yes, date of last chemotherapy treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Illness | Yes | No |
| Arthritis/ Joint Problems |  |  |
| Asthma |  |  |
| Aneurysm |  |  |
| Back problems |  |  |
| Bowel Problems |  |  |
| Broken Bones |  |  |
| Cancer (any kind) |  |  |
| Circulation Problems |  |  |
| Collagen Vascular Disease (Lupus) |  |  |
| Convulsions/ Epilepsy |  |  |
| Deep Vein Thrombosis |  |  |
| Depression/ Anxiety Seizures |  |  |
| Diabetes |  |  |

|  |  |  |
| --- | --- | --- |
| Illness | Yes | No |
| Heart Attack/ Problems |  |  |
| High Blood Pressure |  |  |
| HIV/ AIDS |  |  |
| Kidney Infections/ Stones |  |  |
| Liver Disease |  |  |
| Migraines Headaches |  |  |
| Osteoporosis |  |  |
| Pneumonia/ Lung Disease |  |  |
| Rheumatic Fever |  |  |
| Stroke |  |  |
| Thyroid Disease |  |  |
| Tuberculosis |  |  |
| Other:  |  |  |

**Personal Past History of Illnesses**

Current Medications (including hormones, vitamins, herbs, nonprescription medications): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History**

Operation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

General reason for surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consent**
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 massage or 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 of which I am aware. 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.
\*Please Note: Manual Lymphatic Drainage (MLD) is a very powerful modality and certain medical conditions are contraindicated and determine if and when you 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 us.

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

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

Consent to Treatment of Minor:

By my signature below, I hereby authorize SoulShine Massage Therapy to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Zero Tolerance Policy**

As Respect Massge members, we have a Zero Tolerance Policy.
We are a professional establishment and hold ourselves to the highest standards of an ethical, boundary-driven practice. Respect Massage members have a zero-tolerance policy for sexual solicitations of any kind. Jokes, innuendo, and inappropriate requests are taken seriously and will result in the swift termination of the session, and you will be liable for payment of the scheduled appointment.

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

 **CANCELLATION POLICY & SCHEDULING RULES:**

**Cancellation Policy:** We understand that unanticipated events happen occasionally in everyone’s life. In our desire to be effective and fair to all clients, the following policies are honored: **12-hour advance notice is required**when canceling & rescheduling an appointment. This allows the opportunity for someone else to schedule an appointment and will allow us to plan our day accordingly. If you are unable to give us 12-hour advance notice you will be charged **50%**of your appointment cost with the card on file. Your card is required to hold your appointment & the cancellation fee must be paid prior to/at your next scheduled appointment. For your convenience, we take cards over the phone or through the website with a requested payment link.
**No-shows**
Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a “no-show.” They will be charged for their “missed” appointment at FULL PRICE of their scheduled appointment type. The card on file will be charged or the fee must be paid with the link provided in text/email prior to next scheduled appointment. Another example of a "no-show": Calling to cancel or reschedule your appointment time right at or after your scheduled appointment time has started.
**Late Arrivals**
If you arrive late, your session may be shortened to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the “full” session you were scheduled for. Out of respect and consideration to your therapist and other customers, pleaseplan accordingly and be on time.
**Gift Certificate Appointment Rules**

If you schedule and are a 'No Show', your gift certificate is void.  If you cancel/reschedule your appointment with less than 12 hours’ notice, your ability to reschedule is at the therapist's discretion. You may be asked to pay the 50% to receive your full gift certificate amount or your session may be cut by half.

\* You can update your appointment at your convenience online if it’s more than 12 hours. Otherwise, you need to call and/or text the business cell phone: 423-443-2266 and/or email. Try to reach us by all methods to ensure we receive the message. You cannot text the reminders back, it does not get to us. \*

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