KEEN KINAESTHETICS.

CLIENT INTAKE FORM— MANUAL LYMPHATIC DRAINAGE

Name _____ Date of Birth _____

Address _____

Email _____

Phone number _____

Emergency Contact name & Relationship _____

Emergency Contact number_____

*Have you had a massage before? Yes No

*Reason for seeking Manual Lymphatic Drainage? Relaxation/Therapeutic Medical Reason

If for a medical reason, please explain: _____

_____

Please circle if you have any of the following conditions, as they are contraindications to Manual Lymph Drainage:

Y/ N Active cancer

Y/ N Acute infection

Y/ N Acute congestive heart failure

Y/ N Cardiac insufficiency

Y/ N Severe/ongoing hypertension

Y/ N High risk/ history of DVT/ PE

I attest that the following information is true.

_____

Client Name (please print)

_____

Client signature

_____

Date

Circle affected area(s):