
MANUAL LYMPHATIC DRAINAGE INTAKE FORM

Name _____ Today's Date _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Email Address _____ Birthdate _____ Age _____

May we contact you by email to let you know of upcoming workshops and classes? Yes _____ No _____

Whom may we thank for referring you? _____

Height _____ Weight _____ Blood Pressure _____

What is the reason for your visit? _____

Do you have any primary health or emotional concerns? _____

Are you currently taking any prescription drugs? Which ones? _____

Are you currently taking any vitamins or herbal supplements? Which ones? _____

Do you have any allergies? _____ Stress? _____

Do you bruise easily? _____ Car accidents? _____

Have you suffered major trauma in your life? _____

Do you sleep well at night? _____

Do you suffer from constipation or digestive issues? Which ones? _____

Are you sensitive to any smells or essential oils? Which ones? _____

I understand that all information shared in this visit is confidential and **for educational purposes only** and that it is not intended to replace your general medical practitioner. I understand that all bodywork performed is intended to promote health.

Signed _____ Date _____