Brief Medical History Form

(Pages 1–2 completed by client before or at time of service, page 3 completed by therapist)

Date: _____

Name: _____ **DOB:** _____

What is the reason why you are seeking help? _____

_____

Have you received manual lymphatic drainage before? ☐ **Yes** ☐ **No**

If yes, by whom: _____

What are your current symptoms/complaints? _____

_____

Have you had other therapies for the same symptoms/complaints? ☐ **Yes** ☐ **No**

If yes, please explain your experience, success, or lack of success:

_____

What are your treatment goals? _____

_____

Have you had any surgery? ☐ **Yes** ☐ **No**

If yes, list surgeries and dates: _____

_____

_____

Have you had any cancer surgery? ☐ **Yes** ☐ **No**

If yes, where and when: _____

_____

Have you had any lymph nodes removed? ☐ **Yes** ☐ **No**

If yes, how many: _____

Have you ever received radiation therapy for cancer? ☐ **Yes** ☐ **No**

If yes, list area of radiation and dates here: _____

_____

Have you had chemotherapy? ☐ **Yes** ☐ **No**

If yes, how long ago?_____

Have you had any infections (cellulitis)? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Do you have pain? ☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

Do you have any loss of function or mobility? ☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

Do you currently suffer from (or have you had) any of the following?

☐ Asthma	☐ Hyperthyroidism	☐ Crohn's Disease
☐ Bronchitis	☐ Kidney failure	☐ Diverticulitis
☐ Difficulties breathing	☐ Diabetes	☐ Recent abdominal surgery
☐ Irregular heart beat	☐ Infections (cellulitis)	☐ Unexplained pain
☐ Heart edema	☐ Sleep apnea	☐ Deep venous thrombosis (blood clot)
☐ Hypertension	☐ Malignancy (cancer)	☐ Latex allergy
☐ Swelling (edema)	☐	☐

Do you have any allergies? If yes, please explain:

_____

Do you have any other medical problems not listed above? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Are you taking any medication? ☐ **Yes** ☐ **No**

If yes, list medications and amounts here: _____

_____

At the time you are completing this, are you pregnant or is there a chance you could be pregnant?

☐ **Yes** ☐ **No**

Do you exercise regularly? ☐ **Yes** ☐ **No**

If yes, please describe: _____

_____

Is there anything else you would like to tell us at this time? _____

_____

Treatment Plan (This page is to be completed by therapist):

Reason for treatment:

- ☐ General MLD to promote health and relaxation / general detoxification
- ☐ Post-surgical, post-traumatic
- ☐ Lymphedema (also complete lymphedema addendum)
- ☐ Other_____

Contraindications/precautions:

- ☐ Neck treatment
- ☐ Abdominal Treatment
- ☐ History of CHF, DVT, CKD
- ☐ LN precautions _____
- ☐ Other_____

Indicate current findings and MLD sequence:

Key:
Edema (swelling):///
Scar(s): ⁝⁝⁝
Node removal: ♦
Radiation field (if applicable: ☐
Tissue Tignes/fibrosis: ###
Numbness/tingling: ***
Pain: (0= no pain;
10= worst pain)