Massage 4 Life by Kimberly Alvarado, LMT, MLD-C

Additional Waiver for Manual Lymphatic Drainage (4 pages)

Name: _____ Date: _____

Birthday: _____

What is your reason for seeking manual lymphatic drainage? If post-surgery or post-liposuction, please state the procedure(s) performed, the date performed, and the location on your body. Please also let me know if you have had any radiation, how long ago, and on what areas of your body.

Please mark the following as indicated on the image below:

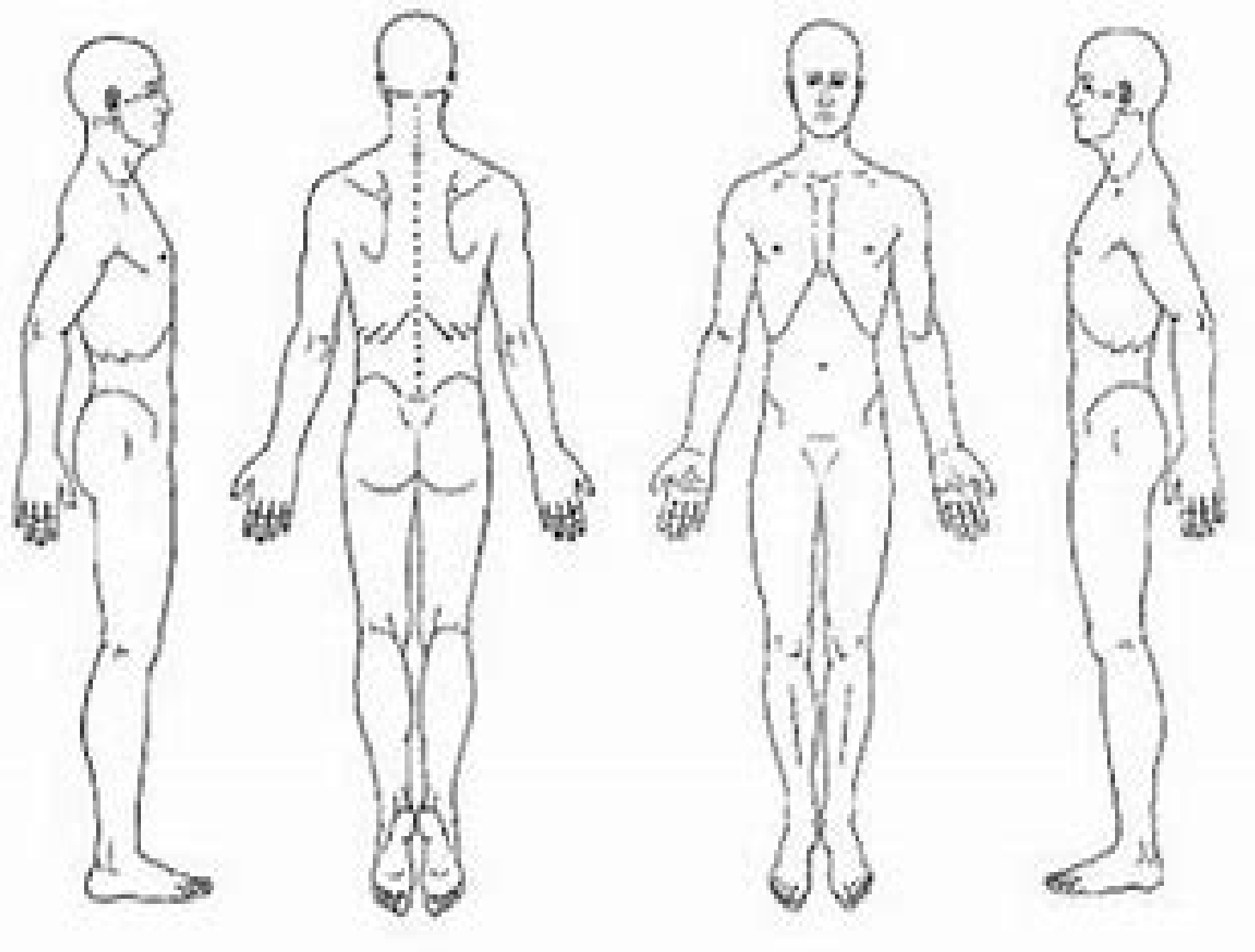
Surgical incisions (open): xxxxxxx (lines of x's)

Healed surgical scars less than 6 weeks old: —----------(dashed lines)

Older scars (larger than 3cm) due to injury or surgery: _____ (regular line)

Circle areas which had liposuction.

X any area that has an open wound.



.Right L R R L Left

Please check any conditions that you have.

- ☐ Acute Infection not treated with antibiotics for at least 24 hours.
- ☐ Fever in the last 24 hours
- ☐ Vomiting in the last 24 hours
- ☐ Cellulitis
- ☐ Acute Congestive Heart Failure (CHF)
- ☐ Past or controlled CHF
- ☐ Short walks cause shortness of breath
- ☐ Unmanaged lymphedema
- ☐ Pregnancy
- ☐ Ileus
- ☐ History of intestinal blockage
- ☐ Diverticulosis, diverticulitis
- ☐ History of aortic aneurysm
- ☐ Current malignancies
- ☐ Renal failure
- ☐ Kidney disease
- ☐ Acute Deep Vein Thrombosis (DVT)
- ☐ HIstory of DVT
  Where? _____
- ☐ Acute Bronchitis
- ☐ Asthma
- ☐ Swelling of unknown cause
- ☐ Dysmenorrhea (painful periods, heavy bleeding, endometriosis, etc.)
- ☐ Currently menstruating
- ☐ Inflammatory conditions of the small or large intestines such as Crohn's disease
- ☐ Recent abdominal surgery (less than 1 year)
- ☐ Unexplained pain in the abdominal area

** Conditions continued on the next page*

Conditions Continued:

- ☐ Lipedema
- ☐ Cardiac arrhythmia
- ☐ Carotid-sinus-syndrome
- ☐ History of stroke
- ☐ Atherosclerosis
- ☐ Carotid endarterectomy
- ☐ Transient ischemic attacks
- ☐ Uncontrolled High Blood Pressure
- ☐ Controlled High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Stents in place
- ☐ Other arterial disease
- ☐ Radiation fibrosis

Therapist Notes and Plan of Care for session: (Leave blank for therapist.)

In addition to the acknowledgements made on my Intake Form, I also acknowledge the following: The statements on this form are true to the best of my knowledge. I will notify Kim Alvarado if there are any changes to my health. I understand that it is important to follow my doctor's advice in addition to receiving manual lymphatic drainage. I understand the plan of care written above. I understand that manual lymphatic drainage is a complement to medical care, not a substitute for medical care.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date