Rising Moon Medical Massage

MANUAL LYMPHATIC DRAINAGE INTAKE FORM

Personal Information

Name _____ DOB _____ Age _____

Address _____

City _____ State _____ Zip _____ Occupation _____

Cell Number _____ Referred by _____

Email address _____

Initial	Office Policies
	I understand that payment is due at the time of service.
	I agree to give at least 48 hours notice of cancellation of appointment or pay for my appointment time in full. Payment for late cancellations or missed appointments is patient responsibility and is due in full before rebooking missed appointments.
	I agree to inform my therapist of any changes to my health/vaccination history.
	This is a natural scent-only office. Please do not wear cologne, aftershave, or perfume to your appointment. It does not wash out of my linens and you will be charged replacement cost.

I, (name)_____ give my permission, for my therapist/practitioner to take notes about me, including health history/medical and/or personal information that I choose to disclose.

This information will be shared with my surgeon/doctor for the purpose of providing coordinated and optimal care.

I understand this information may also be used to contact me for the purpose of scheduling appointments and may be shared with employees of Michelle Rankin and Rising Moon Massage as needed for the purpose of my massage treatment plan.

In addition, Michelle Rankin may communicate with me about my appointments via text at the number above and via email at the address above.

Signature _____ Date _____

660 Jadwin Ste C. Richland
risingmoonmassage@proton.me | Phone 509.947.1751 | Fax 509.984.6616

Surgery Information

Surgery Type_____

Date _____ Doctor _____

Do you have any concerns about your procedure or your healing?_____

_____

Who is your post-surgical care partner?_____

What is your current stress level?_____ Describe _____

Have you received a Covid vaccine? _____ Which vaccine?_____Date_____

Reaction/concerns _____

Have you tested positive for Covid? If so, please describe your illness and lingering concerns _____

Do you use Tobacco?_____Quantity_____ Alcohol?_____Quantity _____

Have you discussed all of the above with your surgeon?_____

Health Information

Allergies - specify allergen & reaction _____

Surgical History (year/type) &/or Recent Procedures _____

_____

Other Hospitalizations_____

_____

Accidents or Physical Traumas _____

_____

Falls/Injuries to Sacrum/head/back/tailbone (describe)_____

_____

Do you have a history of blood clots? _____

Do you have a history of fibrosis? (uterine/breast etc)_____

Have you ever been told that you have venous insufficiency?_____

Do you have a history of abuse or trauma?_____

Women, where are you in life's cycle?_____

Birth control? Type _____

Please Review and Check the Following

Please mark (X) for present and (P) for past

Circulatory

___ Blood Clots
___ Unexplained or Sudden Calf Pain
___ Anemia
___ Hemophilia
___ Pacemaker
___ High Blood Pressure
___ Low Blood Pressure
___ Raynaud's Disease
___ Varicose Veins
___ Cold hands/feet
___ Phlebitis
___ Varicose Veins
___ Diabetes
___ Other Circulatory Issues _____

Nervous System

___ ALS
___ Multiple Sclerosis
___ Parkinson's Disease
___ Bell's Palsy
___ Trigeminal neuralgia
___ Neuritis
___ Stroke
___ Vaccine injury
___ Sciatica
___ Restless Leg
___ Seizures
___ Numbness/Tingling
Where?_____
___ Other Nervous System Issues _____

Skin

___ Fungal Infections
___ Keloid Scarring
___ Warts
___ Athletes Foot
___ Large Moles
___ Ulcers
___ Dermatitis
___ Psoriasis
___ Impetigo
___ MRSA
___ Other Skin Issues

Respiratory

___ Pneumonia
___ Sinusitis
___ Frequent Colds
___ Asthma
___ Trouble Breathing
___ Dizziness
___ Other Respiratory Issues

General

___ Chronic Fatigue
___ HIV/AIDS
___ Lupus
___ Kidney Disease
___ Bladder Infection
___ Pins and Needles feeling
___ Edema or swollen ankles
___ Insomnia
___ Sleep Apnea
___ Anxiety/Panic Attacks
___ Depression
___ Cancer _____
Other_____

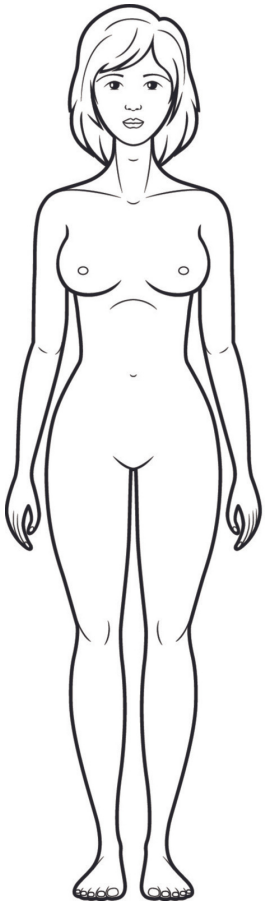
Musculoskeletal

___ Fibromyalgia
___ Spasms/Cramps
___ Sprains/Strains
___ Osteoporosis/Osteopenia
___ Postural Deviations
___ Gout
___ Osteo/Rheumatoid Arth.
___ TMJ Disorder
___ Herniated Disks
___ Spine Fusion
___ Cysts
___ Bursitis
___ Tendonitis
___ Torticollis
___ Disc Herniation
___ Whiplash
___ Carpal Tunnel Synd.
___ Sciatica
___ Thoracic Outlet Syndrome
___ Ankylosing spondylitis
___ Headache
___ Muscle Pain or Cramps
___ Leg Pain
___ Arm Pain
___ Shoulder Pain
___ Low Back Pain
___ Mid Back Pain
___ Hip Pain
___ Neck Pain
Other_____

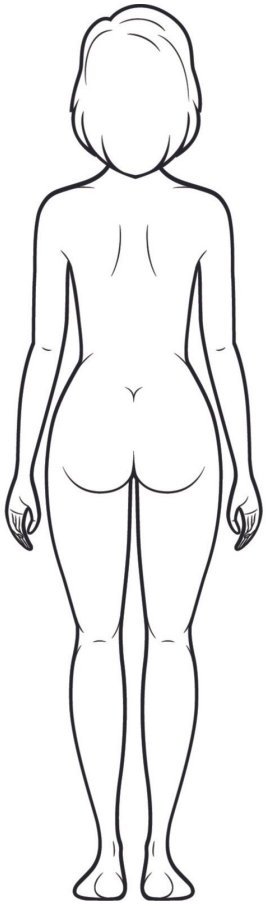
Any other health problems not mentioned above?

Please Mark Surgical Areas and Areas of Lymphatic Concern

Front



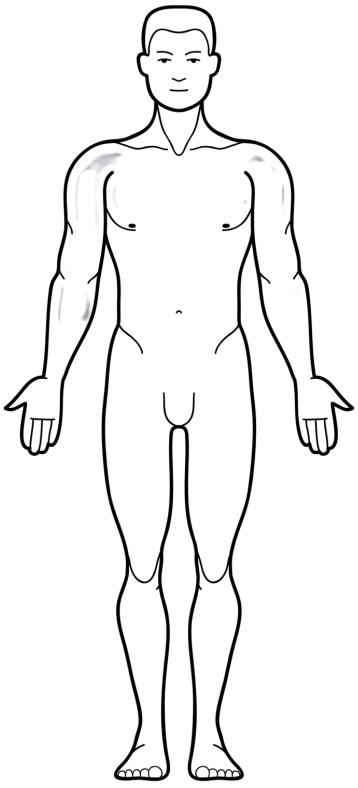
Back



Left

Right

Front



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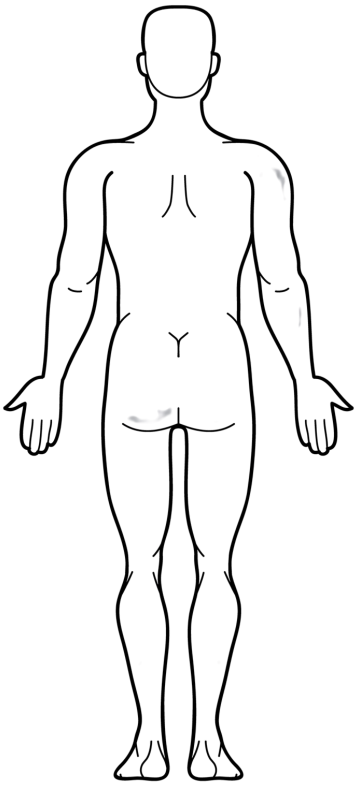

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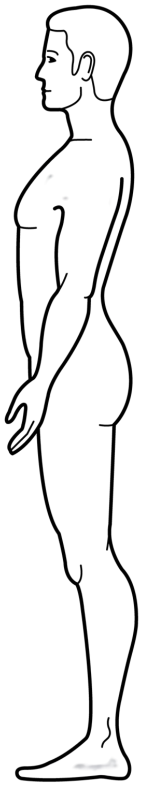

Right

Manual Lymphatic Drainage Client Consent

_____ I understand and acknowledge that healing is a process and there are no guaranteed results with Manual Lymphatic Drainage and that it may take a series of treatments to reach the results I desire.

_____ I certify that the MLD therapy procedure has been explained to me in detail, and I understand that any healing modality, especially used post surgically has some inherent risks. I release my therapist and Rising Moon Massage from any liabilities that may come from or after the receipt of this procedure.

_____ I understand that MLD therapy can be used to aid in lymphatic drainage, and improve circulation and muscle aches, as well as swelling and soreness, however, this is not to be confused as a weight loss supplement.

_____ I certify that the MLD therapy procedure has been explained to me in detail, and I understand that a typical session will include work on my back, glutes, arms, legs, feet, hands, head, face, chest, neck, and shoulders.

_____ Manual Lymphatic Drainage requires skin-to-skin contact. As such, depending on the area being treated, I understand that the therapist will make direct contact with my buttocks and chest. This has been explained to me in full.

_____ Best practices will be followed for modesty draping, however Manual Lymphatic Drainage may require some exposure of breasts and buttocks depending on the area being treated. This has been explained to me in full.

_____ I give permission for my therapist to take pictures of my healing progression. I understand that my pictures will not be used for any purpose other than charting my progress without explicit written consent.

_____ I understand that the following conditions preclude me from having this treatment at this time and verify that none of the following conditions apply to me at this time:

☐ Cardiac Issues ☐ Cancer ☐ Infection ☐ Venous Insufficiency ☐ Metallic Implant ☐ Pregnant/Nursing

_____ I understand and acknowledge that there are risks involved with the treatment I will be receiving including, but not limited to:

☐ Redness ☐ Swelling ☐ Irritation ☐ Skin Reactions ☐ Increased Heart Rate ☐ Headache ☐ Tenderness

I, _____, hereby consent to and authorize Rising Moon Massage to perform on me a MLD (manual lymphatic drainage) therapy on my person.

_____	_____	_____
Client Name	**Signature**	**Date**
(Please Print Clearly)		

Rising Moon Massage Waiver of Liability and Assumption of Risk

I understand that Massage, Manual Lymphatic Drainage, and Manual Therapy Services are for the purposes of stress reduction, pain reduction, relief from muscle tension, and support healing.

I have stated all of my known physical conditions, medical conditions, and medications to Michelle Rankin, and I will keep my massage therapist updated on any changes.

I understand that treatment with Michelle Rankin/Rising Moon Massage/Rankin Coaching, LLC is not a substitute for medical care and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.

Michelle Rankin does not diagnose medical illness, disease, or any other physical or mental conditions and nothing said during the session should be construed as such. Michelle Rankin does not prescribe medical treatment of pharmaceuticals, nor does she perform any chiropractic treatments or spinal manipulations.

If at any point during the Massage and/or Manual Therapy Service I am uncomfortable or uneasy with the treatment being administered and/or if I experience pain, I understand and hereby agree that it is my responsibility to immediately inform the massage therapist, so that the massage therapist may modify massage strokes and pressure to a level of comfort and/or terminate the Massage and/or Manual Therapy Services, if appropriate.

I voluntarily agree to assume all risks involved in receiving Massage and/or Manual Therapy. I give my consent for any Massage and/or Manual Therapy Services provided on the signature date of this document and for any future and past massage therapy sessions. I have read this document and hereby freely give my permission to be massaged and acknowledge and agree that I am doing so at my own risk. My health and safety with respect to all Massage and/or Manual Therapy Services are my sole responsibility. I acknowledge that my receipt of Massage and/or Manual Therapy Services from Michelle Rankin/Rankin Coaching, LLC/Rising Moon Massage may result in bodily injury to me. My decision to receive Massage and/or Manual Therapy Services from Michelle Rankin is voluntary, and I know, understand and assume any and all risks associated therewith.

By signing this document and in exchange for receiving Massage and/or Manual Therapy Services I, for myself and on behalf of my heirs, executors, administrators and personal representatives, hereby waive, release, discharge, and agree to hold harmless for any and all purposes, Michelle Rankin/Rising Moon Massage/Rankin Coaching, LLC, its members officers, employees, and agents from any and all liability for any and all injuries, including death, damages, claims, or demands relating to or resulting from the receipt of the Massage and/or Manual Therapy Services, now or in the future, foreseen or unforeseen.

I further agree to indemnify and hold Michelle Rankin/Rising Moon Massage/Rankin Coaching, LLC, its members, officers, agents, and employees, harmless from and against any and all claims, rights, damages, liabilities, losses, costs, and expenses (including court costs and attorney's fees) arising from or in connection with any injuries to me or other persons or damage to property caused by or attributed to me in connection with my receipt of Massage Services and/or Manual Therapy Services.

Client Printed Name _____

Client Signature_____ Date_____

Therapist signature_____ Date_____