

SunRise Healing Center
Massage/Energy Work, MLD (Manual Lymphatic Drainage)
Client Case History

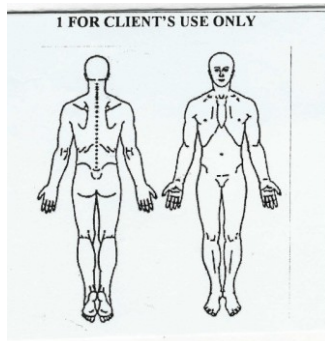
Personal and Confidential Information

Last name: _____ First Name: _____
Address: _____ City: _____
Province: _____ Postal Code: _____ Phone: _____
Bus. # _____ Occupation: _____ Date of Birth: _____
Emergency Contact Name: _____ Phone #: _____
E-mail Address: _____

General and Medical Information

- What brings you in for a massage or/ energy work or MLD? (Stress/pain, relief/tension/other reason) _____

- Is your condition related to work? Yes _____ No _____
- Is your condition related to a car accident? Yes _____ NO _____
- Are you currently having any discomfort and pain? Yes _____ No _____. If yes, where? Please show area on diagram.



- Do you know the cause of the pain? (Disease, specific movement, specific task, weather, other reasons) _____

 - When do you experience the pain? _____. How long have you had the pain? _____

 - How would you describe the pain? (Sharp, dull, burning, numbness, tingling)? Please Describe: _____
 - Is there something that relieves the pain? _____
 - Is there something that aggravates the pain? _____
 - Have you seen your family doctor lately for this particular problem, or other problem, And has she/he recommended any treatment? _____
 - Have you ever had any surgery? If yes, when? _____
- Please describe: _____



- Please describe any other significant injuries, traumas, or accidents (include year and

Treatment): _____

- Do you presently suffer from any of the following? (please circle):

Infectious disease	Headaches	Joint Pain (arthritis)	AIDS HIV positive
Cancer	High blood pressure	Low blood pressure	Tingling/numbness
Muscle cramps	Painful calves	Jaw pain	Flu Cold Allergies
Skin (psoriasis, shingles, others)	Varicose Veins	Sugar Diabetes	Bruise Easily
Acute Viral Inflammation	Acute Bronchitis	Asthma	Chronic Bronchitis
Crones	Hyperthyroidism	DVT (deep vein thrombosis)	

- Do you suffer from any other condition that is not mentioned above? _____

If yes, please describe: _____

- Are you currently taking any medication? _____ If yes, please describe: _____

- Due to the nature of MLD the male or female breast and groin will be touched in order to do MLD massage on these areas. Do you agree that you have this understanding of the nature of this massage?

Yes or No.

Name of Client (Please Print): _____

- I understand that the massage or/ energy work or MLD I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. I further understand that massage or/energy work should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.
- I understand that Massage Therapists and/or MLD Apprentice are not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing said in the course of the session be construed as such.
- Because massage and/or energy work or MLD is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forgot to do so.
- I have received and read the information on MLD (Manual Lymphatic Drainage) and understand all the methods and basic strokes and the necessary placements of hands in order to do the MLD to its full benefit.
- It is also understood that any illicit or sexually suggestive remarks or advances made be me will result in immediate termination of the session, and I will be liable for payment for the full scheduled appointment.

Client Signature: _____ **Date:** _____

If the Clients is of 17 years or younger, the Parent or Guardian must sign below giving the Client permission for treatment and that the Parent or Guardian understands the form above.

Parent or Guardian: _____ **Date:** _____

Therapist: _____ **Date:** _____