MLD Case History Notes and Treatment Record

Date of first visit:

Name; Date of Birth:

Address:

Postcode:
Telephone number: home work Mobile number
Email address:

General Practitioner: Telephone number
Address:

Consultant:

Absolute Contraindications			**Relative contraindications**		
Non treated malignant diseases	yes	no	Treated malignant disease	yes	no
Cardiac Insufficiency	yes	no	Low blood pressure	yes	no
Deep vein Thrombosis	yes	no	Bronchial Asthma	yes	no
Acute inflammation	yes	no	Chronic Inflammation	yes	no
Acute Allergies	yes	no	Pregnancy	yes	no
Lymphoedema	yes	no	Nevus	yes	no
For deep abdominal work	yes	no	Thyroid disorder	yes	no
Inflammatory Bowel Disease	yes	no	Toothache	yes	no
Diabetes	yes	no	Tuberculosis	yes	no
Irradiated abdomen	yes	no	Menstruation	yes	no

Your attention is drawn to the limitations of treatment on your Therapy 1 certificate.

Surgery(current /past history)

Medical Conditions (current/ past history, including allergies)

Medication (prescription/over the counter)

This form is for guidance only and it is the therapist's responsibility to ensure there are no contra-indications to practice and that relative contraindications are considered.

October 2012 V3

Lifestyle

Presenting Pathology and treatment to date

Examination and findings

Treatment Plan

Consent:

Client's signature Date

Therapist's signature Date

Treatment given/outcome

Advice given

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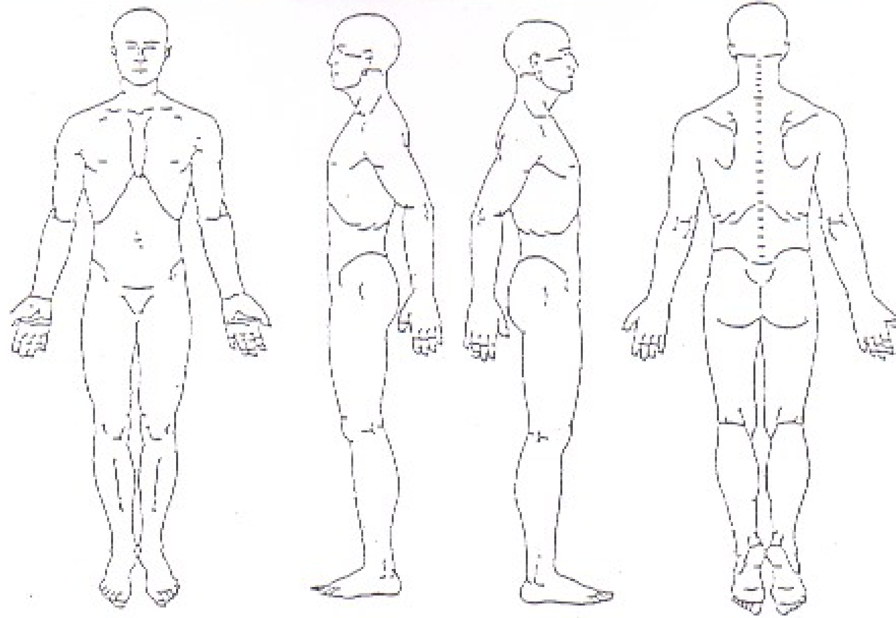
October 2012 V3



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October 2012 V3

Follow-up Record

Date		Full Signature