Harmony Within Massage Therapy

Release for Manual Lymphatic Drainage Treatment

Client: ____

Treatment/Modalities:____________________________________

Physician please complete the following:

Date:____________________

Session time length restrictions, (if any):___________________________

Contraindications: ____

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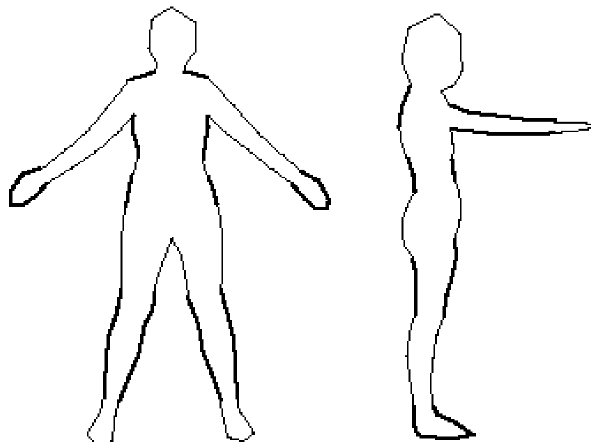
Position restrictions (please check)

SUPINE________ **PRONE**_________ **SIDE-LYING**__________

<u>Site restrictions</u> (Please circle):



Name (Print):_________________________________
Signature:____________________________________ **Date:** __________