Blue Heron, 711 Saint Andrews Blvd., Charleston, SC 29407

Clinical Massage/Lymphatic Treatment Intake Form

Sirena Squires, LMBT SC#11539

Client Contact Information

Name: _____Date of Birth: _____ Date: _____

Address: _____City&Zip_____
Phone: _____Text? **Y / N**
Email: _____
Referred by: _____
Emergency contact: _____ Phone: _____
Physician/Health-care Provider name: _____ Phone: _____

Massage Or Lymphatic Information

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____
_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No
Explain:

_____

List the medications you currently take:

_____

Are you wearing contacts? Yes ☐ No ☐
Are you wearing a hairpiece? Yes ☐ No ☐
(Women) Are you pregnant? Yes ☐ No ☐

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots / infections / congestive heart failure / contagious diseases / pitted edema / kidney stones / pacemaker

Please answer honestly, as massage or lymphatic treatment may not be indicated for the above conditions.

Please indicate conditions that you have:

Fibromyalgia	Shortness of breath, asthma	Osteoporosis, degenerative spine/disk
Numbness or tingling	Cancer	Scoliosis
Swelling	Epilepsy, seizures	Broken bones
Bruise easily	Headaches, Migraines	Allergies
High/Low blood pressure	Digestive conditions (e.g. Crohn's,	Diabetes
Stroke, heart attack	IBS)	Endocrine/thyroid conditions
Varicose veins	Arthritis (rheumatoid, osteoarthritis)	Depression, anxiety

Cancellation Policy: Please be considerate with providing **AT LEAST a 24-hour notice** if you need to change or cancel your appointment. With failure to do so, or with a missed appointment, you will be responsible for a fee equal to half your session cost.

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork 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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ **Date:** _____
Parent or Guardian Signature (in case of a minor): _____ Date: _____