

Pregnancy Massage Client Intake Form

Name _____ Birth Date _____

Address _____ Telephone # _____

City _____ State _____ Zip _____ Email _____

Occupation _____

Emergency phone contact: Name _____ Phone: _____

How did you learn about us? _____

Have you received massage therapy or bodywork before? _____ What kind? _____

How often: _____

Are you on any medication: _____ If yes, what: _____

Do you exercise _____ How many times per week: _____ For how long: _____

Please list and explain other conditions/symptoms you are or have experienced: _____

Have you had any serious or chronic illness, operations, or traumatic accidents: _____

If yes, explain: _____

Prenatal Care Provider/Doctor _____ Telephone _____

May I have permission to contact your care provider? _____

My due date is _____

This is my _____ (1st, 2d, etc.) pregnancy. This will be my _____ (number 1st, 2d ...) birth.

I am _____ (number) weeks pregnant in my _____ (1st, 2d, 3d) trimester

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Please check current problems (X), mark with (+) if you had in the past:

- | | |
|---|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> leaking amniotic fluid* | <input type="checkbox"/> separation of the rectus muscles |
| <input type="checkbox"/> bladder infection* | <input type="checkbox"/> separation of the symphysis pubis |
| <input type="checkbox"/> uterine bleeding | <input type="checkbox"/> skin disorders/athletes foot |
| <input type="checkbox"/> blood clot or phlebitis* | <input type="checkbox"/> twins or more !* |
| <input type="checkbox"/> chronic hypertension | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> abdominal cramping* | <input type="checkbox"/> visual disturbances* |
| <input type="checkbox"/> diabetes (gestational or mellitus) | <input type="checkbox"/> previous cesarean birth |
| <input type="checkbox"/> edema/swelling | <input type="checkbox"/> contagious conditions |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> muscle sprain/strain |
| <input type="checkbox"/> headaches | <input type="checkbox"/> heart attack/stroke |
| <input type="checkbox"/> insomnia | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> leg cramps | <input type="checkbox"/> allergy to nut oils |
| <input type="checkbox"/> miscarriage* | <input type="checkbox"/> low blood pressure |
| <input type="checkbox"/> nausea | <input type="checkbox"/> bursitis |
| <input type="checkbox"/> problems with placenta* | <input type="checkbox"/> hypo or hyperglycemia |
| <input type="checkbox"/> pre-term labor | <input type="checkbox"/> contact lens |
| <input type="checkbox"/> preeclampsia (toxemia)* | <input type="checkbox"/> allergies (i.e., peanut oil) |
- other conditions or problems in current or past pregnancy _____
- _____
- _____

Anything else you would like for me to know: _____

I am experiencing a low risk/high risk (circle one) pregnancy according to my doctor/midwife. If I am currently having or develop complications (any symptoms/conditions listed above with *) I will discuss the condition with my massage therapist, and will have a medical release for bodywork signed by my prenatal care provider before continuing bodywork. I will immediately let my therapist know of any pain or discomfort so that pressure and strokes can be adjusted to my level of comfort.

I have completed this health form to the best of my knowledge. I understand that bodywork is a health aid and does not take the place of a physician's care. Any information exchanged during a massage or bodywork session is confidential and is only used to provide you with the best health care services. I know that massage/bodywork can be harmful in some circumstances; I fully assume responsibility for receipt of massage therapy, and release and discharge the therapist from any and all claims, liabilities, damages, actions from therapy received. I fully and fairly answered these questions and described my health and will tell the practitioner of any changes.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance. If I am late for my appointment, I understand that I will pay the full fee for the time allotted me.

Name _____ Date _____