Pregnancy Massage Client Intake Form

Name _____ Birth Date _____

Address _____ Telephone # _____

City _____ ST _____ Zip _____ Email _____

Occupation _____

Emergency Phone Contact: Name: _____Phone: _____

How did you learn about me? _____

Have you received Massage Therapy or Bodywork before? _____ What Kinds? _____

How often? _____

Are you on any medication? _____ If yes, which ones? _____

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, please explain: _____

_____

Prenatal Care Provider/Doctor_____ Telephone _____

May I have permission to contact your Care Provider? _____

My due date is_____.

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

I am ____(number) weeks pregnant in my ____ (1st, 2nd, 3rd) trimester

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

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

_____

Anything else you would like 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 conditions/symptoms 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 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.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance. If I miss a scheduled appointment without giving 24 notice, I agree pay any missed appointment charge.

I am responsible to pay for any Massage or Bodywork fees not paid for by my insurance company.

Name (signature) _____ Date _____