Pre-Natal Health Information

PERSONAL DATA

Name _____ Date _____ Referred By_____

Address _____

Date of Birth _____ Due Date _____OB/GYN _____

What is the best Phone Number to reach you?_____Best Time? _____
I give my permission for you to leave any information for me, and to use your name/clinic name, at the phone numbers listed above. **_____ Please Intitial**

Would you like to receive emails from Hands of Grace regarding current promotions: Yes____ No ____
(Your email address will not be sold or shared) **Email** _____

Occupation _____ For How Long? _____

Emergency Contact Name & Phone _____

Client Agreement

Please take a moment to read the following. Sign and date where indicated.

- I understand that the information I give on this form is confidential, and will be used for no other purpose than treatment protocol and the therapist's clinical studies.
- I understand that the massage/bodywork I receive is provided for the therapeutic purposes. If I experience any pain or discomfort during my sessions, I agree to inform the therapist immediately so that the pressure and/or technique may be adjusted to my level of comfort.
- Because massage/bodywork is contraindicated under certain health conditions, I affirm that I have disclosed all known health conditions and answered all questions honestly. I agree to keep the therapist updated as to changes in my health and my use of pharmaceuticals, and agree that there shall be no liability on the therapist's part should I not do so.
- It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care and that information provided to me is educational in intent and not diagnostically prescriptive in nature.
- It is understood that the services I receive are strictly therapeutic and non-sexual in intent or practice.

I have read and understand the Notice of Privacy Practices for Protected Health Information, which is posted on the wall of the client waiting area, and I agree to these policies and procedures. **Please initial _____.**

I understand that I am financially responsible for my appointments, and payment is due at the time of service, unless otherwise arranged in advance. **In order to avoid charges, I agree to give 24 hour notice of cancellation**. **Please initial _____.**

_____

Client Signature Date

TREATMENT INFORMATION

What is your main area of discomfort? _____ How do you feel today?_____

Has your OB/GYN consented to you having a massage? _____Have you had massage before? _____

Do you have any allergies? _____

Health Maintenance: Exercise, Supplements, Etc._____

Current Medications:_____

Y/N

Have you ever experienced miscarriage or preterm labor? _____

Do you have an incompetent cervix or other uterine abnormalities? _____

Just prior to or during your pregnancy, did you suffer any abdominal injury or surgery? _____

Are you experiencing any of the following: Placenta Previa, Placenta Abrupto, Diabetes, Renal Disease, Cardiovascular Disease, Systemic Lupus or Other Autoimmune Factors, and/or Preeclampsia/Eclampsia?

_____

_____

Have you had morning sickness, vomiting, diarrhea, or fever? _____

Have you noticed a reduction in fetal movement during the previous 24-hour period? _____

Have you had excessive swelling in your arms, legs, hands, or feet? _____

Do you have poor circulation in your legs? _____

Have you been, or are you currently, inactive or placed on bed rest? _____

Have you experienced any vaginal bleeding or abnormal discharge in the last 24 hours? _____

Are you over age 36 years?_____

During your pregnancy, have you been consuming alcohol, abusing drugs, smoking, or ingesting any other teratogenic agents? _____

Do you have any serious disease? _____

Do you have any contagious wounds? _____

Do you have any recently torn tendons, ligaments, or muscles? _____

Do you have any fractures or infected joints? _____

Do you have any skin, bone, or muscle diseases or infections? _____

Other: _____

_____