

# Pregnancy Massage Client Intake Form

1

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 1<sup>st</sup>, 2<sup>nd</sup>, etc.) pregnancy. This will be my \_\_\_\_\_ (number 1<sup>st</sup>, 2<sup>nd</sup>...) birth.

I am \_\_\_\_\_ (number) weeks pregnant in my \_\_\_\_\_ (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>) trimester

# Pregnancy Massage Client Intake Form

Please check (✓) current problems, 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"/> 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.

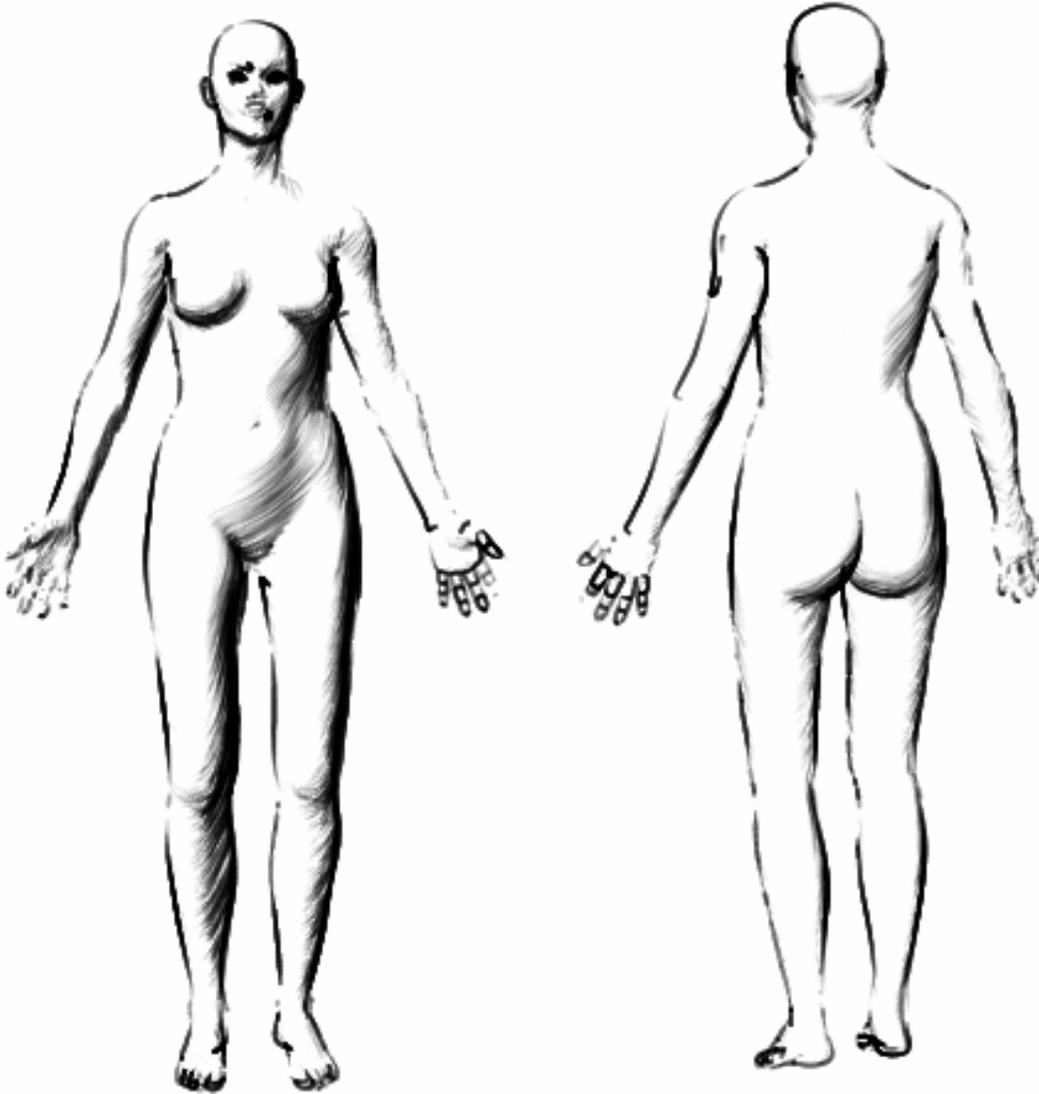
If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance. If I miss a scheduled appointment without giving 24 notice, I agree pay any missed appointment charge.

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

Name (signature) \_\_\_\_\_ Date \_\_\_\_\_

# Pregnancy Massage Client Intake Form

Circle areas of complaint (if any).



Practitioner Notes: