Pregnancy Massage Therapy Intake Form

*** Must have a written note from your Prenatal Care Provider before massage can take place.**

Client Information

Date ________________

Name ____

Address ____

City ______________________ State ____ Zip __________

E-mail ____

DOB ___/____/____ Age ____ Height ______ Weight ______

☐ MARRIED ☐ WIDOWED ☐ SINGLE

☐ SEPARATED ☐ DIVORCED ☐ PARTNERED

Occupation ____

Referred by ____

Primary Physician ___________________________________

Phone Numbers

Home __________________ Cell ______________________

Best time to reach you ____________ am _____________ pm

EMERGENCY CONTACT

Name ____

Home __________________ Cell ______________________

Massage History

Previous massage experience? ☐ YES ☐ NO

How often? ☐ YEARLY ☐ MONTHLY ☐ WEEKLY

Date of last visit ___________

Primary reason for visit? ____________________________

What results would you like to achieve? _________________

____

____

Client Condition

When did symptoms appear?_____________________________

____

What treatment have you already received?

(Circle all that apply)

Medication Surgery Physical Therapy

Chiropractic None Other _____________

Level of discomfort Minor 1 2 3 4 5 6 7 8 9 10 Severe

Type of discomfort

Sharp Dull Throbbing Numbness

Aching Shooting Burning Tingling

Cramps Stiffness Swelling Other ____________

How often do you have this pain? ______________________

Is it constant or does it come and go? ____________________

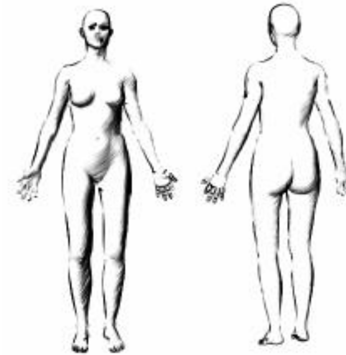
Does it interfere with your (Circle)

Work Sleep Daily Routine Recreation

Contraindication – Reason not to massage an area

____

On the photo below, mark specific area(s) you would like the Massage Therapist to concentrate on during today's session.



Breast massage cannot take place during pregnancy.

Health History

Please mark an (X) for current conditions or a (P) for past conditions

____ Allergies/Sensitivities	____ Circulatory Problems	____ Herniated Disk	____ Pneumonia	____ Thyroid Problems
____ Anemia	____ Constipation/Diarrhea	____ Herpes	____ Polio	____ Tuberculosis
____ Anorexia	____ Diabetes	____ High Blood Pressure	____ Prosthesis	____ Tumors/Growths
____ Arthritis	____ Depression	____ Infectious Diseases	____ Pregnancy	____ Ulcers
____ Asthma	____ Emphysema	____ Jaw Pain/TMJ	____ Rashes	____ Varicose Veins
____ Athlete's Foot	____ Epilepsy	____ Lymphedema	____ Rheumatoid Arthritis	____ Vision Problems/
____ Birth Control/IUD	____ Fatigue	____ Migraine Headaches	____ Rheumatic Fever	Contact Lenses
____ Blood Clots	____ Fibromyalgia	____ Mononucleosis	____ Sinus Problems	____ Whiplash
____ Breathing Difficulty	____ Fractures	____ Multiple Sclerosis	____ Skin Condition(s)	____ Other medical
____ Bursitis	____ Glaucoma	____ Muscle or Joint Pain	____ Sleep Difficulties	conditions not listed
____ Bronchitis	____ Head Injuries	____ Numbness or Tingling	____ Spinal Column Disorders	________________
____ Bulimia	____ Hearing Problems/Deafness	____ Osteoporosis	____ Sprains/Strains	____ Other infectious/
____ Cancer	____ Heart Disease	____ Pacemaker	____ Stroke	communicable
____ Chemical Dependency	____ Hepatitis	____ Parkinson's Disease	____ Tendonitis	diseases not listed
____ Chronic Pain	____ Hernia	____ Pinched Nerve	____ Tension/Stress	________________

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Health History (Continued)

Please mark an (X) for current pregnancy related conditions or a (P) for past conditions

____ Abdominal Cramping *
____ Allergy To Nut Oils
____ Anemia
____ Arthritis
____ Bladder Infection *
____ Blood Clot or Phlebitis *
____ Bursitis
____ Cardiovascular Disease / Heart Attack / Stroke
____ Carpal Tunnel Syndrome
____ Chronic Hypertension *
____ Contact Lens
____ Contagious Conditions
____ Diabetes (gestational or mellitus)
____ Edema/Swelling
____ Fatigue
____ Headaches
____ High Blood Pressure *
____ Hypo or Hyperglycemia
____ Insomnia
____ Leaking Amniotic Fluid *
____ Leg Cramps
____ Low Blood Pressure
____ Miscarriage *
____ Morning Sickness / Vomiting / Diarrhea and Fever
____ Muscle Sprain / Strain
____ Preeclampsia (Toxemia) *
____ Pre-Term Labor *
____ Previous Cesarean Birth
____ Problems With Placenta *
____ Sciatica
____ Separation Of The Rectus Muscles
____ Separation of the Symphysis Pubis
____ Skin Disorders / Athletes Foot
____ Twins or More! *
____ Vaginal Discharge or Uterine Bleeding *
____ Varicose Veins
____ Visual Disturbances *
____ other conditions or problems in current or past pregnancy____

Please explain any areas noted above or on the previous page:

____
____
____

Please list any medical conditions, surgeries, accidents and bone, joint, nerve or muscle diseases or injuries not previously specified.

____ Date: ______________________
____ Date: ______________________
____ Date: ______________________

Anything else you would like me to know?

____
____
____

Medications	Work Activity	Lifestyle
Medications Taken For: ________________________ ________________________ ________________________ ________________________	☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor	☐ Smoking Packs per day ________ ☐ Alcohol Drinks/Week ________ ☐ Coffee/Caffeine Cups/day ________ ☐ High Stress Level Reason ________

Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation:

____
____
____

PRENATAL CARE INFO:

Prenatal Care Provider/Doctor Name ______________________________ Telephone ____________________

May I have permission to contact your Prenatal Care Provider? YES ☐ NO ☐

Note from physician authorizing massage? YES ☐ NO ☐

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

This is my _________(number 1st, 2nd, etc.) pregnancy. This will be my______ (number 1st, 2nd…) birth.

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Privacy Information

I understand that I will be fully draped at all times except for the areas that are being worked on. If I become uncomfortable for any reason during the massage, I can ask the Therapist to cease the massage and the Therapist will end the session.

Information collected by the Therapist will be kept confidential and will not be released without prior written authorization by the client.

Authorization

I am experiencing a **normal low risk** / **high risk** ***(circle one)*** pregnancy according to my Prenatal Care Provider. 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. The information above is accurate and complete to the best of my knowledge and I freely give my permission to be massaged.

I understand that no inappropriate comments or conduct will be tolerated. Any indication of such behavior will automatically end the session.

As massage should not be performed under certain medical conditions, I affirm I have been honest and forthcoming regarding my medical conditions.

I have not taken any medications, drugs, or consumed any alcohol that would make massage therapy detrimental to my health.

I agree to inform the Therapist of any experience of discomfort during the session so that the pressure and/or strokes can be adjusted to my comfort level.

I agree to inform the Massage Therapist in regard to changes in my health and understand that there shall be no liability on the Therapist's part should I forget to do so.

I understand that receiving massage therapy does not deter me from seeking medical treatment for any medical condition.

____ ______________________

Signature of Client, Parent, Guardian or Personal Representative (if Client is under 17, Parent or Guardian must sign) — Date

____ ______________________

Please print name of Client, Parent, Guardian or Personal Representative — Relationship to Client