

Pregnancy Massage Intake Form

Name _____ Phone _____
Occupation _____ How many hours per week on average? _____
Emergency phone contact: Name _____ Phone: _____
Have you received massage therapy or bodywork when you were pregnant? _____
What kind: _____ How often? _____
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, or traumatic accidents since being pregnant: _____
If yes, explain: _____

Prenatal Care Provider/Doctor _____ Telephone _____
May I have permission to contact your care provider if necessary? _____
My due date is _____ This is my _____ (1st, 2nd, etc.) pregnancy.
This will be my _____ (number 1st, 2nd, etc.) birth.
I am _____ (number) weeks pregnant in my _____ (first, second, third) trimester

Current Health Issues

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

- | | |
|---|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> miscarriage* |
| <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 |
| <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"/> problems with placenta* |
| <input type="checkbox"/> nausea | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> leg cramps | <input type="checkbox"/> preeclampsia (toxemia)* |
| <input type="checkbox"/> insomnia | <input type="checkbox"/> pre-term labor |

Other conditions or problems with pregnancy? _____
If yes, explain: _____

Anything else I should 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. 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 about my health and will tell the practitioner of any changes.

Name _____ Date _____