PRENATAL MASSAGE INTAKE FORM

Name _____ Birth Date_____

Address _____

City _____ State _____ Zip _____

Email _____

Cell Phone _____

Occupation _____

Emergency Contact's Name & Number _____

How did you learn about me? _____

Have you received Massage Therapy before? _____ How often? _____

Are you taking any medications? _____ Please list: _____

_____

Do you exercise? _____ How many times/week?_____

Please list conditions/symptoms you are experiencing _____

_____

Have you had any serious or chronic illnesses, operations, or traumatic accidents? _____

If yes, please explain: _____

_____

How are you feeling overall? _____

Prenatal Care Provider/Doctor/Midwife_____ Phone _____

May I have permission to contact your provider? _____

My due date is: _____ and I am in my _____ week of pregnancy.

This is my _____ pregnancy and this will be my _____ birth.

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Do you now, or have you previously had any of these issues? (Please circle)

Allergies	Low Back Pain	Autoimmune Disease	Varicose Veins	Vaginal Bleeding
Anxiety	Upper Back Pain	Lymph Node Removal	Respiratory Issues	Diabetes
Abdominal Pain	Sciatica	Heart Disease	Asthma	Pre term labor
Constipation	Neck/Shoulder Pain	High Blood Pressure	Bladder Infection	Placenta previa
Diarrhea	Swelling in Ankles	Surgery	Fatigue	Placenta abruption
Confusion	Cancer	Anemia	Insomnia	Preeclampsia
Depression	Heart Attack	Liver Disease	Broken Bone	Nausea/Vomiting
Headaches	Twins or more	Kidney Disease	Muscle Sprain/Strain	Incompetent Cervix
Miscarriage	Arthritis	Chemical Dependency	Low Blood Pressure	Ectopic Pregnancy
Symphysis Pubis	Carpal Tunnel	Excessive Bleeding	Previous C-section	Severe Abdominal Pain
				Blood Clot

Do you have any other conditions not listed? _____

_____

I have completed this form to the best of my knowledge and all information is true and accurate. I have disclosed all known health conditions and I will inform the Massage Therapist of any changes to my health status at the beginning of future appointments. I understand that Massage Therapy does not take the place of a physician's care. Any information exchanged at this office is confidential and will only be used with your consent.

If I am unable to make an appointment, I agree to cancel at least 24 hours in advance. If I miss a scheduled appointment, I agree to pay any missed appointment charge.

I release the Massage Therapist of all liability for any harm that may unintentionally occur during my treatment. I consent to the treatment, and I will inform the Massage Therapist immediately if I feel pain or discomfort during a session.

Client Signature _____ Date: _____

Therapist's Signature _____ Date: _____