Pregnancy Massage Therapy Intake Form
CONFIDENTIAL INFORMATION

Today's Date_____

Name Date of Birth

Address

City State Zip

Phone (home) (work/cell) email

Occupation Height Weight (prepregnancy and now)

Emergency contact name & number

Referred by:

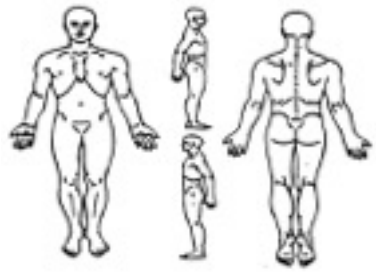
Week of Pregnancy Expected Due Date

Physician Name/Number

Please check any complication or condition you may have experienced in this pregnancy

_____ Multiple pregnancy (twins)
_____ Gestational diabetes
_____ Placental dysfunction
_____ High blood pressure
_____ Pre-eclampsia
_____ Threatened miscarriage
_____ Premature labor
_____ Heart disease
_____ Bladder infection
_____ Swollen hands and/or feet
_____ Varicose veins
_____ Phlebitis
_____ Leg cramps
_____ Restless legs
_____ Headaches
_____ Heartburn
_____ Indigestion
_____ Constipation
_____ Hemorrhoids
_____ Difficulty sleeping

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below. Mark X for pain and 0 for discomfort:_____



Describe any chronic pain/tension_____

What makes it better? _____

What makes it worse?_____

Are you currently under the care of any other physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for? _____

Please list any medications (prescription or non-prescription), vitamins and supplements you are currently taking:

_____

Are you currently receiving any other body or energy therapies? _____

If yes, what for?_____

What specific areas would you like for me to focus on or stay away from? _____

Are there any areas you do NOT like massaged (i.e. feet, stomach, head, face)?_____

What do you hope to accomplish with this massage? (i.e. relaxation, decrease back pain, increase flexibility, etc.)

_____

How frequently and for how long do you exercise and what do you do? Include sports, Pilates, yoga, gardening and/or other physical activities:_____

How many hours of sleep do you receive each night (approximately)?_____
What is your sleeping position? (Normally) _____

Are you right-handed ☐ or left-handed ☐ what is your daily intake of water?_____

Please check any of the following that apply to you in the past or present:

Condition/Complaint	Past	Present	Condition/Complaint	Past	Present
Headaches Type:			**Pins and Needles in arms, legs, Hands or feet**		
Asthma			**Neurological problems**		
Cold Hands/feet			**Spinal Problems**		
Swollen ankles			**Herniated/Bulging Discs**		
Sinus Conditions			**Osteoarthritis**		
Frequent Colds			**Arthritis**		
Allergies (specify above)			**Anxiety**		
Skin Conditions			**Depression/Panic**		
Painful/Swollen Joints			**Sleep Disturbance**		
Auto-immune disorder			**Loss of Memory**		
Cancer			**Whiplash**		
Varicose Veins			**Bruise Easily**		
Blood Clots/DVT			**Constipation/Diarrhea**		
Heart Problems			**Contact Lenses**		
Pacemaker			**Hemorrhoids**		
High/Low BP			**Artificial/Missing limbs**		
Diabetes			**Muscular Tension**		
Epilepsy or Seizures			**Sciatica**		

*Further explanation of any condition or other information:*_____

The following sometimes occurs during massage; they are normal responses to relaxation. Trust your body to express what it needs:

◒*Need to move or change positions*◒*Sighing, yawning* ◒*Stomach gurgling* ◒*Memories*

◒*Emotional feelings and/or expressions* ◒*Movement of intestinal gas* ◒*Energy shifts* ◒*Falling asleep*

PREGNANCY MASSAGE INFORMATION AND INFORMED CONSENT

Massage during pregnancy provides many benefits. It enhances circulation, supporting the work of your heart, and increasing the oxygen and nutrients delivered to your baby. It can relieve the sensation of heaviness and aching in your legs caused by swelling or varicose veins. It can optimize your muscle tone and function, relieve muscle strain and fatigue, and reduce strain on your joints. Pregnancy massage reduces stress and promotes relaxation, contributing to a healthier pregnancy. If you have been told your pregnancy is high-risk, please notify the therapist.

Please read and sign the acknowledgement below:

- I have received and read written information concerning the possible benefits of massage therapy during pregnancy.
- I verify that I am experiencing a low-risk pregnancy, and have stated all my known medical conditions and take it upon myself to keep the therapist/practitioner updated on my health.
- I understand that I will be receiving massage therapy for the purpose of stress reduction, relief from muscle tension or spasm, or for increasing circulation and energy flow.
- I understand that the massage therapist does not diagnose illness, and as such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations.
- I am aware that this massage is not a substitute for medical examination/diagnosis and that it is recommended that I see a physician for any ailment that I might have.
- I understand and agree that I am receiving massage therapy entirely at my own risk. In the event that I become injured either direction or indirectly as a result, in whole or in part, of the aforesaid massage therapy, I HEREBY HOLD HARMLESS AND INDEMNIFY the therapist, their principals, and agents from all claims and liability whatsoever.
- I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
- **I agree to give at least 24 hours notice of cancellation of appointment, otherwise will be expected to pay for session PLEASE INITIAL _____**

Signature_____ Date _____

Print Name: _____

HEALTH CARE PROVIDER'S RELEASE FOR MASSAGE DURING PREGNANCY

To: _____ (Massage Therapist):

_____ (Client's name) is under my supervision for prenatal health care. Her pregnancy is progressing normally. Therapeutic massage would, in my opinion, be an acceptable form of adjunctive care during her pregnancy. I have listed below any limitations in massage procedures for this patient:

_____

_____

_____

(Signature)_____

(Date) _____

Contact Info: Phone & Address _____

_____

_____

PHYSICIAN'S RELEASE FOR THERAPEUTIC MASSAGE/BODYWORK DURING PREGNANCY

_____ (Client), has requested therapeutic massage and bodywork. These services are provided as adjunctive health care. When an individual's pregnancy is high risk, or she has experienced complications in her pregnancy, it is our policy to work with her only if her primary physician has reviewed this request. Please verify your clearance of this request by your signature below. Please also list any precautions or limitations, which you feel to be appropriate. Thank you for your assistance.

Limitations _____

(Signature) _____

(Date) _____