

Prenatal Massage Therapy Intake & Consent Form

Name: _____ Birth Date: ____ / ____ / _____ Age: _____

Address: _____ City: _____ State: ____ ZIP: _____

Phone #: (home) _____ (work) _____ (cell) _____

E-mail address: _____

How did you hear about us: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Regular Medical Doctor: _____

Prenatal Healthcare Provider: _____ Doctor Midwife

Planned Birth Place: _____

Pregnancy Information

I have had _____ previous pregnancies and _____ previous births. I'm carrying one baby twins or more

Estimated Due Date: _____ I am having a boy girl surprise ~ Baby's Name: _____

Have you ever experienced any of the following? Miscarriage Ectopic pregnancy Stillbirth

Previous Births Most Recent <--- to ---> Least Recent

Birth date:					
Cesarean birth:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
< 38wks premature:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth was induced:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child's name:					

Pregnancy Related Conditions

Please indicate any **pregnancy related** conditions you have experienced either in this current pregnancy (check "C" box) or in any past pregnancies (check "P" box):

- | | | | |
|---|---|---|--|
| C - P | C - P | C - P | C - P |
| <input type="checkbox"/> <input type="checkbox"/> Preterm Labor | <input type="checkbox"/> <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> <input type="checkbox"/> Dizziness/Fainting |
| <input type="checkbox"/> <input type="checkbox"/> Pre-Eclampsia | <input type="checkbox"/> <input type="checkbox"/> Sinus Concerns | <input type="checkbox"/> <input type="checkbox"/> Pain in Pubic Bone | <input type="checkbox"/> <input type="checkbox"/> Anemia |
| <input type="checkbox"/> <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> <input type="checkbox"/> Swelling (Edema) | <input type="checkbox"/> <input type="checkbox"/> Round Ligament Pain | <input type="checkbox"/> <input type="checkbox"/> Hyperemesis |
| <input type="checkbox"/> <input type="checkbox"/> Uterine Abnormalities | <input type="checkbox"/> <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> <input type="checkbox"/> Sciatica | <input type="checkbox"/> <input type="checkbox"/> Morning Sickness |
| <input type="checkbox"/> <input type="checkbox"/> Hypertension, High BP | <input type="checkbox"/> <input type="checkbox"/> Vulvar Varicosities | <input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Pain | <input type="checkbox"/> <input type="checkbox"/> Restricted Breathing |
| <input type="checkbox"/> <input type="checkbox"/> Placental Dysfunction | <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids | | |
| <input type="checkbox"/> <input type="checkbox"/> IUGR/SGA | | | |

Lifestyle & Occupation

Please circle the answer closest to how you presently feel (1 = poor, 5 = excellent):

Quality of sleep	1	2	3	4	5
Energy level	1	2	3	4	5
Exercise habits	1	2	3	4	5
Fluid intake	1	2	3	4	5

Occupation: _____

How many hours per week on average? _____

How do you spend most of your work day?

- Sitting Sitting w/ mostly computer work Standing
 Light manual labor Manual labor Hard Manual Labor

Current Stress Level: Constant Moderate Mild None

Other Health History

Do you have any other underlying or pre-pregnancy health complications:

List any hospitalizations, major accidents, major illnesses and surgeries (include approximate DATES):

List all medications, vitamins, minerals, or supplements you are taking: _____

List all known allergies (including medications, foods, seasonal, oils/lotions, scents etc.):

Have you ever received massage therapy before? No Yes (Date of last massage: _____)

Policies If you need to reschedule your appointment, please give me AT LEAST 4 HOURS NOTICE so that I can fill the space. If you do not show up for an appointment I will bill you 50% of the service(s) reserved. Please understand that this policy is in place because I do my best to respect you and your time and I expect the same from you in return. I reserve the right to substitute with an equally qualified massage therapist in the event I am sick or otherwise unable to serve you.

Consent for Care I hereby state that the above information that I have filled in is true and accurate to the best of my knowledge. I authorize my massage therapist to communicate with my Medical Doctor or Prenatal Healthcare Provider as deemed necessary for my treatment. I understand that my personal and medical information (both written and spoken) is confidential and will only be disclosed to third parties with my permission. I also understand that I am expected to notify my LMP if there are any changes to my health/pregnancy OR if I am uncomfortable with ANY part of my massage therapy treatments. I am aware that I need to consult with my Prenatal Healthcare Provider PRIOR to receiving massage therapy if I am a high risk pregnancy or am experiencing any contraindicated conditions in which it would be inadvisable for me to receive massage. I understand that I will be receiving massage therapy as an adjunctive form of healthcare only, and that I must continue to receive appropriate medical care from my Prenatal Healthcare Provider.

Signature _____ Date _____