

# **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: \_\_\_\_\_

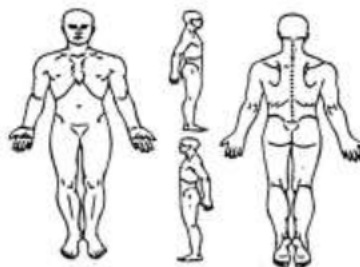
Week of Pregnancy \_\_\_\_\_ Expected Due Date \_\_\_\_\_

Physician Name/Number \_\_\_\_\_

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

- |   |  |
|---|--|
| <input type="checkbox"/> Multiple pregnancy (twins) | <input type="checkbox"/> Varicose veins      |
| <input type="checkbox"/> Gestational diabetes       | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Placental dysfunction      | <input type="checkbox"/> Leg cramps          |
| <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Restless legs       |
| <input type="checkbox"/> Pre-eclampsia              | <input type="checkbox"/> Headaches           |
| <input type="checkbox"/> Threatened miscarriage     | <input type="checkbox"/> Heartburn           |
| <input type="checkbox"/> Premature labor            | <input type="checkbox"/> Indigestion         |
| <input type="checkbox"/> Heart disease              | <input type="checkbox"/> Constipation        |
| <input type="checkbox"/> Bladder infection          | <input type="checkbox"/> Hemorrhoids         |
| <input type="checkbox"/> Swollen hands and/or feet  | <input type="checkbox"/> 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			Pins and Needles in arms, legs, Hands or feet		
Type:			Neurological problems		
Asthma			Spinal Problems		
Cold Hands/feet			Herniated/Bulging Discs		
Swollen ankles			Osteoarthritis		
Sinus Conditions			Arthritis		
Frequent Colds			Anxiety		
Allergies (specify above)			Depression/Panic		
Skin Conditions			Sleep Disturbance		
Painful/Swollen Joints			Loss of Memory		
Auto-immune disorder			Whiplash		
Cancer			Bruise Easily		
Varicose Veins			Constipation/Diarrhea		
Blood Clots/DVT			Contact Lenses		
Heart Problems			Hemorrhoids		
Pacemaker			Artificial/Missing limbs		
High/Low BP			Muscular Tension		
Diabetes			Sciatica		
Epilepsy or Seizures					

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 directly 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):

\_\_\_\_\_ (patient'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

\_\_\_\_\_ (patient), 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) \_\_\_\_\_