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:	❑	❑	❑	❑	❑
< 38wks premature:	❑	❑	❑	❑	❑
Birth was induced:	❑	❑	❑	❑	❑
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
- ❑ ❑ Preterm Labor
- ❑ ❑ Pre-Eclampsia
- ❑ ❑ Gestational Diabetes
- ❑ ❑ Uterine Abnormalities
- ❑ ❑ Hypertension, High BP
- ❑ ❑ Placental Dysfunction
- ❑ ❑ IUGR/SGA

C - P
- ❑ ❑ Headaches/Migraines
- ❑ ❑ Sinus Concerns
- ❑ ❑ Swelling (Edema)
- ❑ ❑ Varicose Veins
- ❑ ❑ Vulvar Varicosities
- ❑ ❑ Hemorrhoids

C - P
- ❑ ❑ Leg Cramps
- ❑ ❑ Pain in Pubic Bone
- ❑ ❑ Round Ligament Pain
- ❑ ❑ Sciatica
- ❑ ❑ Carpal Tunnel Pain

C - P
- ❑ ❑ Dizziness/Fainting
- ❑ ❑ Anemia
- ❑ ❑ Hyperemesis
- ❑ ❑ Morning Sickness
- ❑ ❑ Restricted Breathing

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 _____