Prenatal Massage Intake Form

Date: ____ /____ / ____

Name: _____ Birthday: ____ /____ / ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Emai1: _____

Date of first massage appointment: ____ /____ / ____

Expected due date: ____ /____ / ____

Number of pregnancies: _____ Number of births: _____

Pre-natal care provider: _____

Have you ever experienced a therapeutic massage before? _____

Have you experienced pregnancy massage before? _____

Are you currently taking any medications? _____ If so, what are they?

_____

Have you taken any medications prior to this pregnancy?

_____

Do you currently have any areas of discomfort?

_____

Do you have any past injuries or surgeries that I should know about?

_____

What is your current occupation? _____

Does it involve long periods of (please check all that apply):

☐ sitting / ☐ standing / ☐ computer terminal work / ☐ telephone work / ☐ other

When do you plan to begin maternity leave? ____ /____ / ____

Do you have any history of: (please check all that apply):

☐ high blood pressure
☐ low blood pressure
☐ morning sickness/nausea
☐ heartburn
☐ edema
☐ varicose veins
☐ pre-term labor
☐ thyroid problems
☐ headaches
☐ constipation
☐ diarrhea
☐ hemorrhoids
☐ sinus congestion

I do hereby understand that the services offered are not a substitute for medical care, and any information provided by the therapist is for educational purposes only. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

_____ _____

Client Signature Date