



Pregnancy Massage Client Intake Form

Name _____ Birth Date _____

Address _____ Telephone # _____

City _____ ST _____ Zip _____ Email _____

Occupation _____

Emergency Phone Contact: Name: _____ Phone: _____

How did you learn about us? _____

Have you received Massage Therapy or Bodywork before? _____ What Type? _____

How often? _____

Are you on any medication? _____ If yes, which ones? _____

Do you exercise? _____ How many times per week? _____ For how long? _____

Please list and explain other conditions/symptoms you are or have experienced:

Have you had any serious or chronic illness, operations, or traumatic accidents? _____

If yes, please explain: _____

Prenatal Care Provider/Doctor _____ Telephone _____

May I have permission to contact your Care Provider? _____

My due date is _____.

This is my _____ (number 1st, 2nd, etc.) pregnancy. This will be my _____ (number 1st, 2nd...) birth.

I am _____ (number) weeks pregnant in my _____ (1st, 2nd, 3rd) trimester

Pregnancy Massage Client Intake Form

Please check (✓) current problems, mark with (+) if you had in the past :

- | | |
|--|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> leaking amniotic fluid * | <input type="checkbox"/> separation of the rectus muscles |
| <input type="checkbox"/> bladder infection * | <input type="checkbox"/> separation of the symphysis pubis |
| <input type="checkbox"/> uterine bleeding * | <input type="checkbox"/> skin disorders/ athletes foot |
| <input type="checkbox"/> blood clot or phlebitis * | <input type="checkbox"/> twins or more! * |
| <input type="checkbox"/> chronic hypertension * | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> abdominal cramping * | <input type="checkbox"/> visual disturbances * |
| <input type="checkbox"/> diabetes (gestational or mellitus) | <input type="checkbox"/> previous cesarean birth |
| <input type="checkbox"/> edema/swelling | <input type="checkbox"/> contagious conditions |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> muscle sprain / strain |
| <input type="checkbox"/> headaches | <input type="checkbox"/> heart attack / stroke |
| <input type="checkbox"/> insomnia | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> high blood pressure * | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> leg cramps | <input type="checkbox"/> allergy to nut oils |
| <input type="checkbox"/> miscarriage * | <input type="checkbox"/> low blood pressure |
| <input type="checkbox"/> nausea | <input type="checkbox"/> bursitis |
| <input type="checkbox"/> problems with placenta * | <input type="checkbox"/> hypo or hyperglycemia |
| <input type="checkbox"/> pre-term labor * | <input type="checkbox"/> contact lens |
| <input type="checkbox"/> preeclampsia (toxemia) * | |
| <input type="checkbox"/> other conditions or problems in current or past pregnancy _____ | |

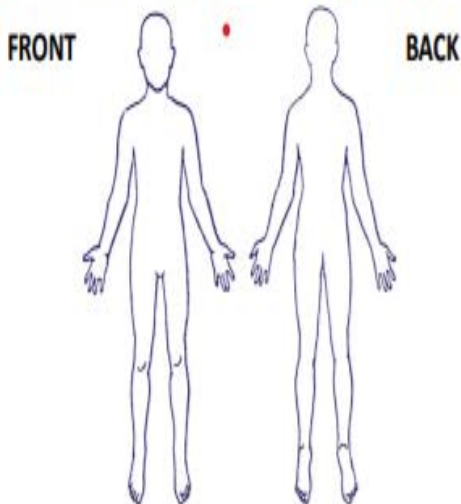
Anything else you would like us to know? _____

I have completed this health form to the best of my knowledge. I understand that Bodywork is a health aid and does not take the place of a physician's care. Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance. If I miss a scheduled appointment without giving 24 notice, I agree pay any missed appointment charge.

Name (signature) _____ Date _____

Indicate on **DIAGRAM** any areas you want **FOCUSED**



Indicate on **DIAGRAM** any areas you want **AVOIDED**

