Prenatal Massage

Date of initial visit ____.____.____

Name _____ Pronoun _____

Legal Name (if different from above)

_____

Address _____

Preferred phone number _____

Email _____ Date of birth _____

Occupation _____

Emergency contact name and phone number _____

_____

How did you find me? _____

Client Confidentiality and Release Form

I, (name)_____, give my permission for this practitioner to take notes including health history/medical and/or personal information I choose to disclose to her and that this information will be treated as confidential. Furthermore, I understand that massage/bodywork should not be construed as a substitute for medical care. I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment, I am subject to a fee equal to the cost of the missed appointment.

Client Signature _____ Date: _____

Practitioner Signature _____ Date:_____

A parent or legal guardian must give informed written consent for any client under age 18.

REASON FOR VISIT

Primary reason for visit _____

When did you first notice it? _____

Are there any causes or patterns you noticed? _____

_____

Was there an emotional, spiritual or physical event(s) that occurred around the onset? _____

_____

Are there activities that provide relief? _____

Are there activities that make it worse? _____

Have you had massage/bodywork before? _____

If so, when and what type? _____

What's your massage frequency style? (E.g., Some of my clients prefer weekly, biweekly, others every third week and then some monthly or bi-monthly.)

_____

Do you sit for long hours at a workstation, computer, or driving? Yes No

If so, what type(s)? _____

_____

HEALTH HISTORY

Are you currently pregnant? Yes No

If so, how many weeks? _____

What number pregnancy is this for you?

_____

How many children do you already have, and what are their ages?

_____

Briefly explain any history of miscarriage:

_____

Briefly explain any history of fertility issues:

_____

Are you currently taking any medications or supplements? Yes No

If yes, please list.

_____

Have you recently experienced any of the following accidents or traumas? (bone break/fracture, injury, surgery, vehicle accident, joblessness, death of a loved one, sexual assault, etc.) _____

_____

_____

Please check any health issues that apply to you, and circle those that are currently present for you.

( ) Allergies/sensitivity
( ) Artificial joint
( ) Atherosclerosis
( ) Back/neck ailments
( ) Cancer
( ) Carpal tunnel syndrome
( ) Circulatory disorder
( ) Contagious skin condition
( ) Decreased sensation
( ) Deep vein thrombosis/blood clots
( ) Diabetes
( ) Difficulty sleeping
( ) Easy bruising
( ) Epilepsy

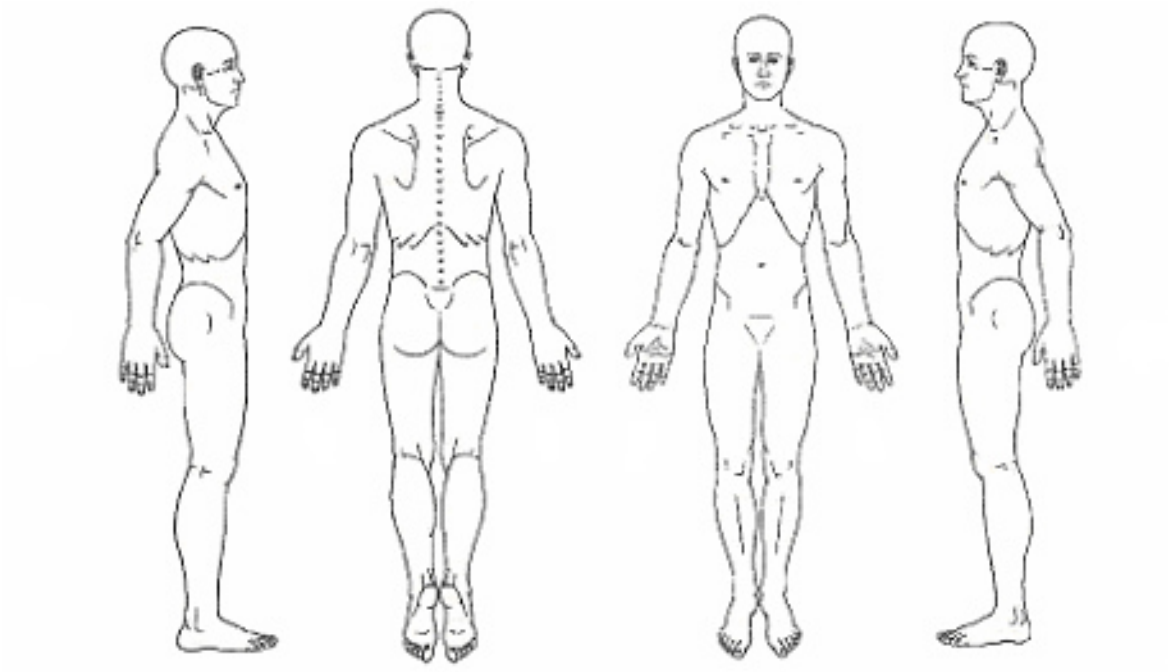
( ) Fever
( ) Frequent urination
( ) Heart condition
( ) High or low blood pressure
( ) Joint disorder/tendonitis
( ) Osteoarthritis
( ) Phlebitis
( ) Rheumatoid arthritis
( ) Sprains/strains
( ) Swollen glands
( ) Varicose veins
( ) Fibromyalgia
( ) Headaches/migraine
( ) Heartburn
( ) High risk pregnancy
( ) Open sores or wounds
( ) Osteoporosis
( ) Prenatal or postpartum depression
( ) Restless legs
( ) Sciatic pain
( ) TMJ

Please explain any additional conditions that apply to you:

_____
_____
_____
_____

Please list any injuries/illnesses still affecting you:

_____
_____
_____
_____



Are there any places you'd like me to focus and/or avoid?

_____

_____

_____