Pregnancy Massage Intake

Maternal Massage

Name: _____ Age: _____Gestational Weeks:_____

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

I am a **low** risk or **high** risk pregnancy according to my health care provider.

My prenatal care provider is _____ Ph: _____
May I, as your Massage Therapist, contact your care provider?.

Please mark current health concerns/problems, that you have had in the past with an "x":

_ abdominal cramping
_ anemia
_ bladder infection
_ blood clot/phlebitis
_ breech presentation
_ carpal tunnel syndrome
_ chronic hypertension
_ constipation
_ diabetes (gestational or mellitus)
_ dizziness/light-headedness
_ edema/swelling
_ fatigue
_ headaches
_ high blood pressure
_ heart bum/acid reflux
_ hypo or hyperglycemia
_ insomnia
__leaking amniotic fluid
__leg cramps
__low blood pressure
__miscarriage
__muscle sprain/strain
__nausea/vomiting
__preeclampsia
__placenta previa (other abnormalities)
__pre-term labour
__previous caesarean section
__sciatica
__separation of abdominal muscles
__separation of pubic symphysis
__twins plus
__uterine bleeding
__varicose veins
_ visual disturbances

Other conditions/concerns in this pregnancy or past pregnancies: _____

_____

Any other relevant information: _____

_____

Consent to Treat with Massage Therapy

I have discussed any complications and concerns with my Massage Therapist. New complications and concerns, if they do arise, will be discussed with my massage therapist, and appropriate action will be taken. I will have a medical release form for Massage signed by my healthcare provider if requested.

Signature: _____ Date :_____