MIND BODY BABY

PRENATAL MASSAGE THERAPY
CLIENT INTAKE FORM

CLIENT INFORMATION			
			Date:
Name:			
D.O.B:		**Age:**	
Address:	*(Street)*		
	(City)	*(State)*	*(ZIP)*
Phone:			
	(Home)	*(Cell)*	*(Work)*
Email:			
Occupation:			
Height:			
Weight (pre-pregnancy):		Weight (current):	
Emergency contact (Name):			
Relationship:		Phone:	
Referred by:			
Week of pregnancy:			
Estimated due date:			
Physician's Name:		Phone:	
Intended place of birth:			
What number pregnancy is this for you?			
How many children do you have, and what are their ages?			
Do you have a history of miscarriage? Y / N **Do you have a history of infertility? Y / N**		*Office use only*	

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Please circle any complications or conditions you may have experienced this pregnancy.

Multiple pregnancy (twins)	Y / N	Varicose veins	Y / N
Gestational diabetes	Y / N	Phlebitis	Y / N
Placental dysfunction	Y / N	Leg cramps	Y / N
High blood pressure	Y / N	Restless legs	Y / N
Pre-eclampsia	Y / N	Headaches	Y / N
Threatened miscarriage	Y / N	Heartburn	Y / N
Premature labour	Y / N	Indigestion	Y / N
Heart disease	Y / N	Constipation	Y / N
Bladder infection	Y / N	Hemorrhoids	Y / N
Swollen hands and/or feet	Y / N	Difficulty sleeping	Y / N
Carpal tunnel	Y / N	Depression	Y / N
Hyperemesis	Y / N	Anxiety	Y / N

Is there anything else about your pregnancy that you think would be useful for your massage practitioner to know in order plan a safe and effective massage session for you?

____

____

Medications

Please list any medications (prescription and non-prescription), vitamins and supplements you are currently taking:

____

____

Allergies

Do you have any allergies? (food, medication, oils/lotions/ointments, etc.) **Yes / No**

If yes, please specify: ____

Pregnancy History

Date of Delivery	Type of Delivery (Vaginal, Caesarean, VBAC)	Complications

Termination(s) / Dates: Miscarriage(s) / Dates:

Fertility problems:

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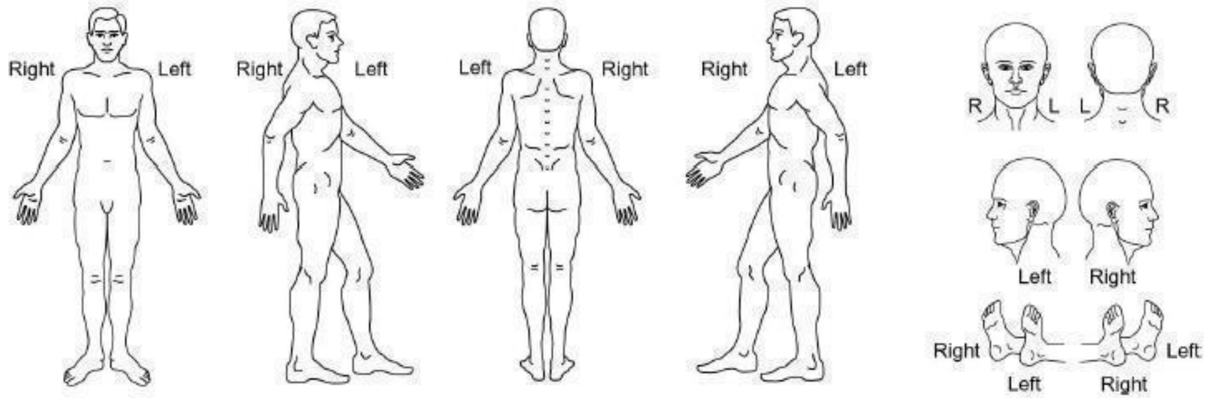
Please use the diagram below to indicate any area(s) of pain and/or discomfort.



Are you currently experiencing pain and/or discomfort? **Yes / No**

If yes, please provide a brief explanation: ____

____

What makes it better? ____

What makes it worse? ____

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

If yes, please describe: ____

Do you perform any repetitive movement in your work, sports, or hobby? **Yes / No**

If yes, please describe: ____

Do you have any particular goals in mind for this massage session? **Yes / No**

If yes, please explain:

Do you have sensitive skin? **Yes / No**

Are you wearing contact lenses? **Yes / No**

Are you wearing a hearing aid? **Yes / No**

Have you had a professional pregnancy massage before? **Yes / No**

Are there any areas you do NOT like massaged (i.e. feet, stomach, head, face)? **Yes / No**

If yes, please specify: ____

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General Health History

Please check any of the following that apply to you in the past or present:

Condition / Complaint	Past	Present	Condition / Complaint	Past	Present
Headaches Type:			Pins and needles in arms, legs, hands or feet		
Contagious skin condition			Neurological problems		
Open sores or wounds			Spinal problems		
Easy bruising			Herniated/bulging discs		
Sprains/strains			Whiplash		
Recent accident or injury			Loss of memory		
Recent fracture			Epilepsy or seizures		
Recent surgery			Muscular tension		
Artificial joint			Sciatica		
Arthritis			Constipation/diarrhea		
Osteoarthritis			Haemorrhoids		
Painful/swollen joints			Swollen ankles		
Swollen glands			Blood clots/DVT		
Heart condition			Varicose veins		
Pacemaker			Sinus conditions		
High blood pressure			Frequent colds		
Low blood pressure			Asthma		
Diabetes			Allergies/sensitivities		
Cancer			Decreased sensation		
Auto-immune disorder			Anxiety		
Cold hands/feet			Depression		
Carpal tunnel			Sleep disturbances		

Please explain any condition that you have marked above.

Are you currently under the care of a doctor or alternative medicine practitioner? **Yes / No**

If yes, what are you being treated for?

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Lifestyle

On a scale of 1-10, indicate your current level of stress.

1	2	3	4	5	6	7	8	9	10
Low				Mod					High

How many hours of sleep do you receive each night?

Do you have restful sleep?

What do you do for relaxation?

How much water do you consume daily?

Describe your typical diet (e.g. some organic, no processed foods, low caffeine).

Describe your current exercise routine (e.g. type of exercise, how often and for how long).

Please provide any additional information that you feel is important for your practitioner to know.

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PREGNANCY MASSAGE INFORMATION & INFORMED CONSENT

Massage during pregnancy offers many benefits. It enhances circulation which provides more oxygen and nutrients to both mother and baby. It can relieve the sensation of heaviness and aching in your legs caused by swelling or varicose veins. It can optimize your muscle tone and function, relieve muscle strain and fatigue, and reduce strain on your joints. Pregnancy massage reduces stress and promotes relaxation, contributing to a healthier pregnancy. If you have been told that your pregnancy is high-risk, please notify your therapist.

Please read and sign the acknowledgement below:

I have received and read written information concerning the possible benefits of massage therapy during pregnancy.

I verify that I am experiencing a low-risk pregnancy, and have stated all my known medical conditions and take it upon myself to keep the therapist/practitioner updated on my health.

I understand that I will be receiving massage therapy for the purpose of stress reduction, relief from muscle tension o spasm, or for increasing circulation and energy flow.

I understand that the massage therapist does not diagnose illness, and as such, the massage therapist does not prescribe medical treatment or pharmaceuticals, not do they perform and spinal manipulations.

I am aware that this massage is not a substitute for medical examination/diagnosis and that it is recommended that I see a physician for any ailment that I might have.

I understand and agree that I am receiving massage therapy entirely at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy, I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims of liability whatsoever.

I understand that payment is due at the time of treatment unless arrangements have been made otherwise.

Client's Name (please print) _______________________________

Client's Signature ____ **Date:** ______________