



Patient Information - Prenatal Massage Therapy

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_
Email: \_\_\_\_\_
How did you find us? \_\_\_\_\_

Prenatal Care Provider/Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_
My due date is \_\_\_\_\_ This is my \_\_\_\_\_ (number 1st, 2nd) pregnancy.
This will be my \_\_\_\_\_ (number 1st, 2nd) birth. I am \_\_\_\_\_ (#) weeks pregnant.
Are you on any medication? Yes/No If yes, which ones? \_\_\_\_\_

Do you have any allergies towards scented/unscented oils, lotions or creams? Yes/No If yes, please specify \_\_\_\_\_
Please list and explain other conditions/symptoms you are or have experienced: \_\_\_\_\_

Have you had a serious or chronic illness, operations, or traumatic accidents? Yes/No If yes, please explain: \_\_\_\_\_

Pulse rate: \_\_\_\_\_ Blood pressure: Low/Normal/High Cholesterol: Low/Normal/High

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

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

Have you had a professional massage before? Yes/No How often? \_\_\_\_\_
Any areas you would like for your therapist to concentrate on? \_\_\_\_\_

Do you exercise? Yes/No How many times per week? \_\_\_\_\_ For how long? \_\_\_\_\_

In case of emergency, whom should we call? Phone: \_\_\_\_\_
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I am experiencing a low risk /high risk (circle one) pregnancy according to my doctor/midwife. If I am currently having or develop complications (any conditions/symptoms listed above with\*) I will discuss the condition with my massage therapist and will have a medical release for massages signed by my prenatal care provider before continuing any services. I have completed this health form to the best of my knowledge. I understand that a massage is a health aid and does not take the place of a physician's care. Any information exchanged during a massage session is confidential and is only used to provide you with the best health care services.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Notes:

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