Intake & Consent Form for Prenatal Massage Therapy

Name: _____ Birth Date: _____ /_____ / _____ Age: _____

Address: _____ City: _____State: _____ ZIP: _____

Phone #: (home) _____ (work) _____ (cell) _____

E-mail address: _____

How did you hear about me: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Regular Medical Doctor: _____

Prenatal Healthcare Provider: _____❑Dula ❑Doctor ❑Midwife

Pregnancy Information

I have had _____ previous pregnancies and _____ previous births. I'm carrying ❑one baby ❑twins or more

Estimated Due Date: _____ I am having a ❑boy ❑girl ❑surprise

Pregnancy Related Conditions

Please indicate any pregnancy related conditions you have experienced either in this current pregnancy (check "C" box) or in any past pregnancies (check "P" box):

C - P	C - P	C - P	C - P
❑ ❑Preterm Labor	❑ ❑Headaches/Migraines	❑ ❑Leg Cramps	❑ ❑Dizziness/Fainting
❑ ❑Pre-Eclampsia	❑ ❑Sinus Concerns	❑ ❑Pain in Pubic Bone	❑ ❑Anemia
❑ ❑Gestational Diabetes	❑ ❑Swelling (Edema)	❑ ❑Round Ligament Pain	❑ ❑Hyperemesis
❑ ❑Uterine Abnormalities	❑ ❑Varicose Veins	❑ ❑Sciatica	❑ ❑Morning Sickness
❑ ❑Hypertension, High BP	❑ ❑Vulvar Varicosities	❑ ❑Carpal Tunnel Pain	❑ ❑Restricted Breathing
❑ ❑Placental Dysfunction	❑ ❑Hemorrhoids		
❑ ❑IUGR/SGA			

Lifestyle & Occupation

Please circle the answer closest to how you presently feel (1 = poor, 5 = excellent):

Quality of sleep	1	2	3	4	5
Energy level	1	2	3	4	5
Exercise habits	1	2	3	4	5
Fluid intake	1	2	3	4	5

Occupation: _____

How many hours per week on average? _____

How do you spend most of your work day?

❑Sitting ❑Sitting w/ mostly computer work ❑Standing

❑Light manual labor ❑Manual labor ❑Hard Manual Labor

Current Stress Level: ❑ Constant ❑ Moderate ❑ Mild ❑ None

Other Health History

Do you have any other underlying or pre-pregnancy health complications?

_____

_____

_____

_____

List any hospitalizations, major accidents, major illnesses and surgeries:

_____

_____

List all medications, vitamins, minerals, or supplements you are taking:

_____

_____

List all known allergies (including medications, foods, seasonal, oils/lotions, scents etc.):

_____

_____

Have you ever received massage therapy before? ❑No ❑Yes (Date of last massage: _____)

Do you see a chiropractor? ❑No ❑Yes (Date of last visit: _____)

Additional Concerns You may have with your massage today:

_____

Consent for Care I hereby state that the above information that I have filled in is true and accurate to the best of my knowledge. I authorize my massage therapist to communicate with my Medical Doctor or Prenatal Healthcare Provider as deemed necessary for my treatment. I understand that my personal and medical information (both written and spoken) is confidential and will only be disclosed to third parties with my permission. I also understand that I am expected to notify my Licensed Massage Therapist if there are any changes to my health/pregnancy OR if I am uncomfortable with ANY part of my massage therapy treatments. I am aware that I need to consult with my Prenatal Healthcare Provider PRIOR to receiving massage therapy if I am a high risk pregnancy or am experiencing any contraindicated conditions in which it would be inadvisable for me to receive massage. I understand that I will be receiving massage therapy as an adjunctive form of healthcare only, and that I must continue to receive appropriate medical care from my Prenatal Healthcare Provider.

Signature _____ Date_____