

Pregnancy Massage Therapy Intake & Consent Form

ABOUT YOU

Name: _____ Age: _____

Address: _____

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

E-mail address _____

Emergency Contact: _____ Relationship: _____

Phone #: _____

Regular Medical Doctor: _____

Maternity Healthcare Provider: _____ Doctor Midwife

PLEASE FILL IN WHAT APPLIES TO YOU

I'm pregnant

This is my first pregnancy

I'm carrying one twins more: _____

I'm due: _____ I'm _____ weeks Starting mat leave: _____ (approx date)

I have birthed one or more babies in the past

Youngest < _____ > Oldest

Birth date: _____

Child's age: _____

Cesarean birth

< 38 wks gestation

Birth was induced

CURRENT &/OR PAST PREGNANCIES

Please indicate any pregnancy complications that you have experienced (miscarriage, ectopic pregnancy, premature labour, (pre)eclampsia, gestational diabetes, etc):

Please indicate any PREGNANCY RELATED conditions you have experienced either in this CURRENT pregnancy (tick first box) or in any PAST pregnancies (tick second box):

- Muscle cramps Varicose veins Vulvar varicosities` Groin pain
- Headaches Sinus concerns Hemorrhoids Hip pain
- Carpal tunnel pain Anxiety/ Depression Neck pain Thigh/leg pain
- Sciatica Fatigue Upper back pain Foot pain
- Constipation/Gas Nausea Mid back pain Rib/thorax pain
- Restricted breathing Stress Low back pain Shoulder pain
- Swelling (edema) High/low blood pressure Pelvic pain Arm/hand pain

General Health

Please list any other health concerns that you have that are unrelated to your pregnancy

CONSENT FOR TREATMENT

I hereby state that the above information that I have filled in is true and accurate to the best of my knowledge. 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 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 Midwife/Healthcare Provider PRIOR to receiving massage therapy Especially if I am a High Risk Pregnancy or am experiencing any contraindicated conditions in which it would be inadvisable for me to receive massage.

Patient Signature: _____ Print Name: _____

Date: _____