



Pregnancy Massage Client Intake Form

Name: _____

Ob/Gyn/Midwife handling your care: _____ Phone: _____

Due Date: _____ How many weeks postpartum: _____

Do you have any complications or medical issues with your pregnancy?

No Yes If yes, please describe:

Do you have any swelling? No Yes Sometimes

Do you have any changes in veins? No Yes If yes, where: _____

Have you been pregnant before? No Yes # of times? _____

Types of births you have had in the past:

cesarean vaginal hospital home birthing center

Where are you planning to give birth? Home Birth Birthing Home Hospital

Will you be attempting a V-BAC (vaginal birth after cesarean)? _____

Please describe anything you'd like to address in the session today, and/or any areas of concern:

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Please check if you have any of the following symptoms or conditions:

<input type="checkbox"/> Fevers	<input type="checkbox"/> Diagnosed incompetent cervix
<input type="checkbox"/> Flu, Acute illness	<input type="checkbox"/> Any vaginal bleeding or discharge
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Pain in the abdomen that is new / unexplained
<input type="checkbox"/> Any pitting edema	<input type="checkbox"/> Excessive swelling in arms, legs or face
<input type="checkbox"/> Bruising	<input type="checkbox"/> Pregnancy Induced Hypertension (PIH)
<input type="checkbox"/> Rashes or local skin infections	<input type="checkbox"/> Medication for depression, thyroid
<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> History of miscarriage or pregnancy complications, twins
<input type="checkbox"/> Gestational diabetes	
<input type="checkbox"/> Placental Abnormality	<input type="checkbox"/> Premature rupture of the membranes or history of that
<input type="checkbox"/> Premature labor	

I, _____, have read this entire form including the contraindications listed above. I attest that I have none of the above conditions, nor do I have any medical problems whatsoever. I am in general good health.

I am aware that I am being massaged by _____. I agree to hold my massage therapist and Massage Therapy Connections harmless in the event of any medical/health problem being experienced by me during or after the massage.

I have read and I understand what has been stated above. I have answered all questions and have supplied personal information honestly and accurately. I realize that if I have been dishonest, I could endanger my, or my unborn child's, health.

Signature _____ Date _____