Pregnancy Massage Therapy Intake Form
CONFIDENTIAL INFORMATION

Today's Date_____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work/cell) _____ email _____

Occupation _____ Height _____ Weight (prepregnancy and now) _____

Emergency contact name & number _____

Referred by: _____

Week of Pregnancy _____ Expected Due Date _____

Physician Name/Number _____

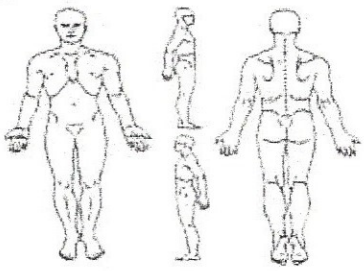
Please check any complication or condition you may have experienced in this pregnancy

_____ Multiple pregnancy (twins)
_____ Gestational diabetes
_____ Placental dysfunction
_____ High blood pressure
_____ Pre-eclampsia
_____ Threatened miscarriage
_____ Premature labor
_____ Heart disease
_____ Bladder infection
_____ Swollen hands and/or feet

_____ Varicose veins
_____ Phlebitis
_____ Leg cramps
_____ Restless legs
_____ Headaches
_____ Heartburn
_____ Indigestion
_____ Constipation
_____ Hemorrhoids
_____ Difficulty sleeping

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below. Mark X for pain and 0 for discomfort:_____

_____



Describe any chronic pain/tension_____

What makes it better? _____

What makes it worse?_____

Are you currently under the care of any other physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for? _____

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

Are you currently receiving any other body or energy therapies? _____

If yes, what for? _____

What specific areas would you like for me to focus on or stay away from? _____

Are there any areas you do NOT like massaged (i.e. feet, stomach, head, face)? _____

What do you hope to accomplish with this massage? (i.e. relaxation, decrease back pain, increase flexibility, etc.) _____

How frequently and for how long do you exercise and what do you do? Include sports, Pilates, yoga, gardening and/or other physical activities: _____

How many hours of sleep do you receive each night (approximately)? _____
What is your sleeping position? (normally) _____

Are you right-handed ☐ or left-handed ☐ What is your daily intake of water: _____

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		
Asthma			Neurological problems		
Cold Hands/feet			Spinal Problems		
Swollen ankles			Herniated/Bulging Discs		
Sinus Conditions			Osteoarthritis		
Frequent Colds			Arthritis		
Allergies (specify above)			Anxiety		
Skin Conditions			Depression/Panic		
Painful/Swollen Joints			Sleep Disturbance		
Auto-immune disorder			Loss of Memory		
Cancer			Whiplash		
Varicose Veins			Bruise Easily		
Blood Clots/DVT			Constipation/Diarrhea		
Heart Problems			Contact Lenses		
Pacemaker			Hemorrhoids		
High/Low BP			Artificial/Missing limbs		
Diabetes			Muscular Tension		
Epilepsy or Seizures			Sciatica		

Further explanation of any condition or other information: _____

The following sometimes occurs during massage; they are normal responses to relaxation. Trust your body to express what it needs:

Need to move or change positions *Sighing, yawning* *Stomach gurgling* *Memories*

Emotional feelings and/or expressions *Movement of intestinal gas* *Energy shifts* *Falling asleep*