Prenatal Massage Therapy Intake Form Date ____________________________

Name ____________________________ Phone Number _________________________________

Address __________________________ Town ____

State ____ Zip Code ______ Date of Birth ____________________________________

Estimated Due Date _______________ Weeks Gestation Now __________ Age _________

Planned Birth Site _________________ Midwife/Doctor __________________________________

Occupation ________________________ Activities/Exercise ______________________________

Partner/Spouse/Other Contact Person ____

Names & Ages of Children ____

Have you had a massage before? If so, what kind? ____

Primary reason for appointment ____

Goals of treatment ____

Areas you prefer therapist to avoid ____

Please circle/describe/give dates if you have a **HISTORY** of any of the following. Your honesty helps provide appropriate care for you and all information is completely confidential.

Comments:

Skin Sensitivities _____________________________________

Cancer ____

Hypertension ____

Herpes ____

Arthritis ____

Asthma ____

Allergies ____

Artificial Implants _____________________________________

Vascular Problems _____________________________________

Sexual Abuse ____

Domestic Violence _____________________________________

Diabetes ____

Phlebitis ____

Fractures/Dislocations _____________________________

Medications _____________________________________

Since you have been pregnant have you experienced any of the following?

Sciatica	Swelling	Back Pain
Nausea/Vomiting	Constipation	Numbness/Carpal Tunnel Syndrome
Breathlessness	Urinary Frequency	Heartburn
Headache	Vaginal Bleeding	Low Blood Sugar
Nasal Congestion	Varicose Veins	Low Blood Pressure
Preterm Labor	Round Ligament Pain	Skin Problems

Other: ____

Referred by: ____

Signature ____