Heart of Life Massage, LLC

Prenatal Client Intake Form

Name ___________________________________ Birth Date ______________________

Address _______________________________________ Telephone ______________________

City _____________________ State ________________ Zip __________ Email ________________

Occupation ____

Emergency Contact ____________________________ Phone _____________________

How did you hear about me? ____

Have you ever received Massage Therapy before? ___________ What kind? _______________

How often? ____

Are you on any medication? __________ If yes, please list __________________________________

Do you exercise? ___________ How many times per week? _______ For how long? ______________

Please list and explain any other conditions/symptoms you are or have experienced:

Have you had any serious or chronic illness, operations, or traumatic accidents? __________
If yes, please explain ____

Prenatal Care provider/ Doctor _______________________________ Telephone _______________

May I have permission to contact your care provider? ___________

My due date is _______________

This is my ________ (1st, 2nd, etc) pregnancy. This will be my __________ (1st, 2nd, etc) birth

I am _____ (number) weeks pregnant in my ______ (1st, 2nd, 3rd) trimester

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Please check current problems and mark with + if you've had them in the past:

[ ] anemia*	[ ] sciatica
[ ] leaking amniotic fluid*	[ ] separation of the rectus muscles
[ ] bladder infection*	[ ] separation of the pubis symphysis
[ ] uterine bleeding*	[ ] skin disorders/athletes foot
[ ] blood clot or phlebitis*	[ ] twins or more*
[ ] chronic hypertension*	[ ] varicose veins
[ ] abdominal cramping*	[ ] visual disturbances*
[ ] diabetes (gestational or mellitus)	[ ] previous cesarean birth
[ ] edema/swelling	[ ] contagious conditions
[ ] fatigue	[ ] muscle sprain/strain
[ ] headaches	[ ] heart attack/stroke
[ ] insomnia	[ ] arthritis
[ ] high blood pressure*	[ ] carpal tunnel syndrome
[ ] leg cramps	[ ] allergy to nut oils
[ ] miscarriage*	[ ] low blood pressure
[ ] nausea	[ ] bursitis
[ ] problems with placenta*	[ ] hyperglycemia
[ ] pre-term labor*	[ ] hypoglycemia
[ ] preeclampsia (toxemia)*	[ ] contact lenses

Please list any other conditions or problems in current or past pregnancy:

____

____

Anything else you would like me to know?

____

____

I am experiencing a low/high (circle one) risk pregnancy according to my Doctor/Midwife. If I am currently having or develop complications (any conditions/symptoms listed above with *) I will discuss the condition with my massage therapist, and will have a medical release for massage signed by my prenatal care provider before continuing any further massage(s).

I have completed this health form to the best of my knowledge. I understand that Massage is a health

aid and does not take the place of a physician's care. Any information exchanged during a Massage session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel that appointment 24 hours in advance. If I miss a scheduled appointment without giving 24 hour notice, I agree to pay 50% of any missed appointment charge.

I am responsible to pay for any Massage fees not paid for by my insurance company.

Name (signature) ____ Date _____________