Hands on Relief

Deborah Flynn LMT

# Pregnancy Massage Intake Form

Some conditions may require special permission from your doctor. Please obtain clearance from your doctor if you have had any complications during your current pregnancy, or any previous pregnancies. Read through the following statement carefully, and tell your therapist if you have any conditions listed below. Please do not sign unless the following statement is absolutely truthful.

I, _____ , am experiencing a low risk pregnancy, and am receiving medical care including regular checkups throughout my pregnancy. Massage therapy is contraindicated for pregnant women in cases where the client is/has experienced **abdominal or pelvic pain**, **cramping**, or **bleeding**. I do not have a history of **embolism** or **varicose veins**. I do not have a **urinary tract infection**, or **pre-eclampsia**.

Signed _____ Date_____

I understand that I will be receiving massage therapy as a form of adjunctive health care only and that this therapy is not intended to replace appropriate medical care.

Having been duly advised of the risks and contraindications to massage therapy during pregnancy, I have decided to participate in the therapy. Accordingly, I do forever release the practitioners and their insurers, and their employees and agents from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving massage therapy during this childbearing year.

I further agree to hold harmless and defend the practitioner of and from all actions, claims, or other legal or administrative action that has arisen or may arise directly from my and my child's participation in this therapy.

Signed _____ Date_____

Print Name _____