



Prenatal Intake and Consent Form

Name: _____

Date: _____

Preferred Phone number: _____

Email _____

What trimester are you in today? _____ Due Date: _____

Have you had prenatal massage before? (check on) Yes____ No____

Is your pregnancy considered to be high risk? (check one) Yes____ No____

If yes, what are the reasons?

Have you had any complications or problems in this pregnancy? (Please explain)

Prenatal Care Provider/Doctor _____ Telephone _____

My due date is _____.

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

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

Prenatal Massage Therapy Benefits - There are several observed or identified potential benefits to massage therapy during pregnancy, including:

- Relieves muscular tension, especially in the lower back, upper back, shoulders and neck
- Reduces stress on weight-bearing joints
- Enhances body awareness for better posture and less discomfort
- Assists with body mechanics and movement during structural change
- Supports birth process by relaxing muscles involved in labor and birth
- Eases anxiety and stress during time of transition
- Provides emotional support and nurturance

Prenatal Massage Therapy Contraindications – Performing massage therapy during pregnancy is contraindicated for women experiencing any of the following symptoms/signs:

- Bloody discharge
- Continual abdominal pains
- Sudden gush or leakage of amniotic fluid
- Sudden, rapid weight gain
- Increased blood pressure
- Severe back pain that does not subside with change in position
- Visual disturbances
- Severe nausea and/or vomiting (cannot keep anything down)
- Eclampsia

- Severe headaches
- Excessive hunger and thirst
- Fever
- Diarrhea
- Excessive swelling in arms or legs
- Decrease in fetal movement over a 24-hour period
- Additional conditions – phlebitis, thrombosis, or suspected clotting conditions, any kidney, liver or spleen compromise or infection. Local massage on areas with severe varicose veins and swelling are avoided due to clotting risk.

For our clients' safety, we require a doctor's release form in order to receive massage therapy during a High Risk Pregnancy, which includes, but is not limited to:

- Early labor, miscarriage threat, placental or cervical dysfunction
- Gestational Edema
- Proteinuria
- Hypertension (GEPH)
- Preeclampsia
- Gestational Diabetes
- Pre-existing cardiac, renal, connective tissue or liver disorders/diseases
- Fetal genetic disorders
- Complications in previous pregnancies
- Three or more miscarriages

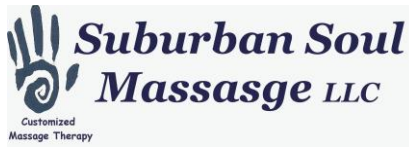
Pregnancy Massage Client Intake Form

Please check (√) current problems, mark with (+) if you had in the past :

- | | |
|---|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> blood clot or phlebitis * |
| <input type="checkbox"/> leaking amniotic fluid * | <input type="checkbox"/> chronic hypertension * |
| <input type="checkbox"/> bladder infection * | <input type="checkbox"/> abdominal cramping * |
| <input type="checkbox"/> uterine bleeding * | <input type="checkbox"/> edema/swelling |
| <input type="checkbox"/> diabetes (gestational or mellitus) | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> headaches | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> high blood pressure * | <input type="checkbox"/> leg cramps |
| <input type="checkbox"/> miscarriage * | <input type="checkbox"/> nausea |
| <input type="checkbox"/> problems with placenta * | <input type="checkbox"/> pre-term labor * |
| <input type="checkbox"/> sciatica | <input type="checkbox"/> preeclampsia (toxemia) * |
| <input type="checkbox"/> separation of the symphysis pubis | <input type="checkbox"/> separation of the rectus muscle |
| <input type="checkbox"/> skin disorders/ athletes foot | <input type="checkbox"/> Eptopic Pregnancy* |
| <input type="checkbox"/> twins or more! * | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> visual disturbances * | <input type="checkbox"/> previous cesarean birth |
| <input type="checkbox"/> muscle sprain / strain | <input type="checkbox"/> contagious conditions |
| <input type="checkbox"/> heart attack / stroke* | <input type="checkbox"/> arthritis _ |
| <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> allergy to nut oils | <input type="checkbox"/> low blood pressure |
| <input type="checkbox"/> hypo or hyperglycemia | <input type="checkbox"/> bursitis |

Other conditions or problems in current or past pregnancy _____

Anything else you would like me to know?



Please read and sign below, to continue with treatment:

I am experiencing a low risk / high risk (circle one) 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 massage.

I have completed this health form to the best of my knowledge. I understand that massage is to relieve muscular tension and aid in relaxation, and does not take the place of a physician's care. Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services.

I understand that massage therapy is a health aid and does not take the place of a physicians' care. Any information exchanged during a massage session is confidential and is only used to provide the best massage care. If I am having or develop any complications, I will discuss with my massage therapist. If I feel any discomfort or pain at all during the massage I will inform my massage therapist at once.

I hereby voluntarily release Suburban Soul Massage,LLC and its therapists from any liability should my condition be aggravated at any time. By signing below, I agree that I have read the information above and have decided to receive a prenatal massage at my own risk. I affirm that I have stated all know medical conditions and answered all questions honestly. I agree to keep therapist updated on all changes in my medical profile and understand that the therapist will not be held liable for my failure to do so

I, _____, have received and understood the information on these pages about the benefits and possible contraindications of massage therapy during pregnancy, and confirm that: (Please check all boxes that apply)

I have not experienced any the complications listed; I have not experienced any of the conditions listed, which would make it unwise to have massage therapy; I am experiencing a low-risk pregnancy; I am receiving medical care including regular check-ups throughout my pregnancy.

I AM experiencing a high-risk pregnancy or have decided to have a 1st-trimester massage, but have given a doctor's release form to my massage therapist

Printed Name:_____

Signed:_____

Date:_____

Therapists Signature_____

Date:_____