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:

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

___ 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, ______________________________________, 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:________________