Journey Therapeutic Massage

Prenatal and Health History Form

Client Name: _____Date: _____
Date of Birth: _____
Address: _____
Phone: _____Email: _____
Referred by: _____

What discomforts, pain or other needs are you hoping to have addressed through this massage therapy session?

In What week of pregnancy are you? _____

Are you regularly seeing a physician, nurse-midwife or midwife? Please provide name and phone number. _____

Have you had any complications or problems with this pregnancy: Circle those that apply: bleeding, cramping, amniotic fluid leakage, swelling, high blood pressure, rapid weight gain, protein in urine, vision disturbances, severe nausea, vomiting, or headaches, abnormal fetal growth, heartbeat, or movements, high blood sugar, other.

Do you have any medical conditions? Circle those that apply:

Diabetes, heart, liver, kidney, or lung disorders, convulsive disorders, uterine abnormality, connective tissue or collagen diseases, other.

Are you currently experiencing any infection or disorder? Circle those that apply:

Cold; bladder, breast, scar or other infection; skin irritation; varicose veins; other.

Is your pregnancy considered to be high risk (due to diabetes, hypertension, multiple pregnancy, previous complicated pregnancy, asthma, Rh or genetic problems, age under 20 or over 35 years of age, fetal genetic disorders, or exposure to hazardous materials)?

Is there other relevant information about this pregnancy or about you that I should know?
