

# Prenatal Form

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Prenatal Care Provider/Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

May we have permission to contact your care provider? \_\_\_\_\_

My due date is: \_\_\_\_\_

This is my \_\_\_\_\_ (1<sup>st</sup>, 2<sup>nd</sup>, etc.) pregnancy. This will be my \_\_\_\_\_ (number 1<sup>st</sup>, 2<sup>nd</sup>, etc.) birth.

I am \_\_\_\_\_ (number) weeks pregnant and in my \_\_\_\_\_ (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>) trimester.

Please check if you have any of the following:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Sciatica         | <input type="checkbox"/> Leaking Amniotic Fluid |
| <input type="checkbox"/> Edema/Swelling   | <input type="checkbox"/> Infections       | <input type="checkbox"/> Uterine Bleeding       |
| <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Insomnia         | <input type="checkbox"/> Chronic Hypertension   |
| <input type="checkbox"/> Abdominal Cramping                                       | <input type="checkbox"/> Carpal Tunnel    | <input type="checkbox"/> Miscarriage            |
| <input type="checkbox"/> Nausea   | <input type="checkbox"/> Placenta Problem | <input type="checkbox"/> Preeclampsia/Eclampsia |
| <input type="checkbox"/> Other conditions or problems in current pregnancy: _____ |   |   |

Anything else you would like for me to know: \_\_\_\_\_

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 symptoms/conditions listed above) I will discuss the condition with my massage therapist, and will have a medical release for bodywork signed by my prenatal care provider before continuing bodywork. I will immediately let my therapist know of any pain or discomfort so that pressure and strokes can be adjusted to my level of comfort.

I have completed this health form to the best of my knowledge. I understand that bodywork is a health aid and does not take the place of a physician's care. Any information exchanged during a massage/bodywork session is confidential and is only used to provide me with the best health care services. I know that massage/bodywork can be harmful in some circumstances; I fully assume responsibility for receipt of massage therapy, and release and discharge the therapist from any and all claims, liabilities, damages, actions from therapy received. I fully and fairly answered these questions and described my health and will tell the practitioner of any changes.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18:

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_