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Please fill out this section if you are pregnant:
Estimated due date: Weeks pregnant:
Medical provider's Name:
Medical provider's Contact Number:
Pregnancy History:
 Have you had any complications during this pregnancy? If yes, please provide details:
 Have you experienced any complications with previous pregnancies and/or do you have a history of more than 3 lost pregnancies? If yes, please provide details:
 Are you currently experiencing any pain, discomfort, or specific concerns related to your pregnancy? If yes, please describe:
Please include any changes to your health that have occurred since becoming pregnant:
Pregnancy massage should always be administered in a relaxing manner. The primary goal of treatment is to provide temporary relief for aches and pains experienced during pregnancy. The pressure you have received during other massage may not be appropriate during prenatal and postnatal massages. Please let your therapist know if you are experiencing any discomfort (Ex: nausea) as in many cases issues are easily resolved. Initial:
Consent to Cupping Therapy:
I, consent to the use of silicone cups during my massage therapy sessions. I understand that there is a possibility of tissue discolouration associated with this type of therapy that may last for a duration ranging from hours to days following treatment. I understand that this colouring is not bruising but is a result of a build up of cellular debris and stagnation being drawn to the surface. I agree to keep my therapist informed of any health changes to ensure accurate assessment of whether cupping therapy is an appropriate treatment option is future sessions.
Initial:
Please sign below to acknowledge that you have read, understood, and agree to the information provided above:
Print name: Date:
Signature:
Please note: By signing this form, you confirm you are of legal age or have obtained appropriate consent if you are signing on behalf of a minor or someone else.