

Client History Form – Pregnancy

PERSONAL INFORMATION

Name _____
 Address _____
 Telephone: Mobile _____ Home _____
 Date of birth _____ Email _____
 Emergency contact name _____ Contact's telephone _____
 Your occupation _____ Employer _____
 Prenatal care provider _____ Provider's telephone _____

MEDICAL HISTORY

Previous pregnancy? _____ Length of gestation: Weeks _____
 Names/Age of Children: _____
 Previous experience with massage during pregnancy: _____
 Current medications, including aspirin, ibuprofen, herbs, vitamins, etc _____

 Primary reason for appointment/areas of pain or tension: _____

Heart/blood circulation disorders	Y/N	Low back pain	Y/N
Spinal disorders	Y/N	Sciatica/gluteal pain	Y/N
Illness	Y/N	Hip pain	Y/N
Injuries	Y/N	Separation of symphysis pubis	Y/N
Surgeries	Y/N	Separation of abdominal muscles	Y/N
Accidents	Y/N	Leg cramps	Y/N
Osteoporosis/Arthritis	Y/N	Carpal tunnel	Y/N
Varicose veins	Y/N	Nausea	Y/N
Allergies/skin problems	Y/N	High blood pressure	Y/N
Headaches	Y/N	Oedema/swelling	Y/N
Pain/numbness	Y/N	Diabetes	Y/N
Bladder infection	Y/N	Preterm labour	Y/N
Uterine bleeding	Y/N	Abdominal cramping	Y/N
Chronic hypertension	Y/N	Preeclampsia	Y/N
Blood clot or thrombophlebitis	Y/N	More than 2 consecutive miscarriages	Y/N
Placenta insufficiency	Y/N	Other conditions or more details on above conditions? Please specify below	Y/N

Any other problems in current or past pregnancy? _____

Types and frequency of stress-reduction activities, hobbies, exercise, or sports participation _____

Most current blood pressure _____

Describe any foetal movement _____

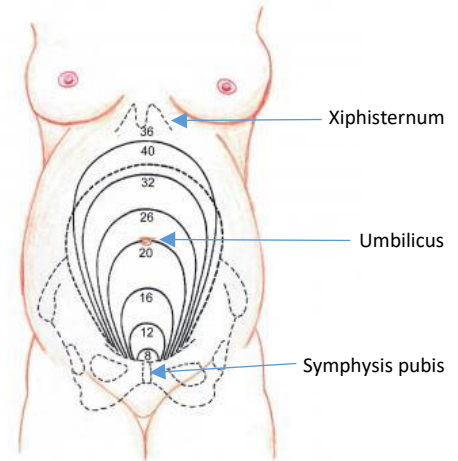
Can you describe your general well-being? _____

Have you experienced any changes since your last visit?

Have you experienced any bleeding? _____

Current medications, including aspirin, ibuprofen, vitamins, homeopathic and natural remedies etc. _____

Name of any other allied health professional you attend on a regular basis e.g. physiotherapist _____



What prompted you to book a massage today and what result are you hoping for? _____

MARKETING

How did you find out about Gemfields Massage Therapies? _____

Do you consent to receive marketing emails? ☐ Yes ☐ No

CONSENT TO TREATMENT

- I, _____ (please print your name) have chosen to consult with and hereby give consent for alternative therapy to be provided by Tracey Ross (the therapist) who I understand has a Diploma of Remedial Massage HLT52015, a Certificate of Pregnancy Massage and is an Emmett Technique Practitioner.
- I have provided a detailed medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned.
- I understand that treatment received may provide benefits for certain conditions but results are not guaranteed. These benefits may include relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions and provision of general well-being.
- I also understand that treatment may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes.
- I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations.
- The therapist understands that I have the right to question procedures used and to receive an explanation of any procedures that the therapist performs.
- I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly.
- The therapist has explained that I have the right to refuse treatment or changes to the treatment and that she or I have the right to stop the massage at any time.
- I undertake to advise the therapist of changes that may occur in any of my conditions at subsequent treatments that may occur.

Signature: _____ Date: _____

Gemfields Massage Therapies is a registered business name to Tracey Ross ABN 57 517 470 179.

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