**Prenatal Massage Therapy Intake & Consent Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Me:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Regular Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prenatal Healthcare Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❏ Doctor ❏ Midwife

Planned Birth Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy Information**

I have had \_\_\_\_\_\_ previous pregnancies and \_\_\_\_\_\_ previous births. I’m carrying ❏ one baby ❏ twins or more

Estimated Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I am having a ❏ boy ❏ girl ❏ surprise ~ Baby’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced any of the following? ❏ Miscarriage ❏ Ectopic pregnancy ❏ Stillbirth

**Previous Births** Most Recent <--- to ---> Least Recent

Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cesarean birth: ❏ ❏ ❏ ❏ ❏ < 38wks premature: ❏ ❏ ❏ ❏ ❏

Birth was induced: ❏ ❏ ❏ ❏ ❏

Childs Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy Related Conditions**

Please indicate any **pregnancy related** conditions you have experienced either in this current pregnancy (check

“C” box) or in any past pregnancies (check “P” box):

C – P C – P C - P

❏ ❏ Preterm Labor ❏ ❏ Pre-Eclampsia ❏ ❏ Gestational Diabetes

❏ ❏ Uterine Abnormalities ❏ ❏ Hypertension, High BP ❏ ❏ Placental Dysfunction

❏ ❏ IUGR/SGA ❏ ❏ Headaches/Migraines ❏ ❏ Sinus Concerns

❏ ❏ Swelling (Edema) ❏ ❏ Varicose Veins ❏ ❏ Vulvar Varicosities

❏ ❏ Hemorrhoids ❏ ❏ Leg Cramps ❏ ❏ Pain in Pubic Bone

❏ ❏ Round Ligament Pain ❏ ❏ Sciatica ❏ ❏ Carpal Tunnel Pain

❏ ❏ Dizziness/Fainting ❏ ❏ Anemia ❏ ❏ Hyperemesis

❏ ❏ Morning Sickness ❏ ❏ Restricted Breathing

**Lifestyle & Occupation**

Please circle the answer closest to how you

presently feel (1 = poor, 5 = excellent):

Quality of sleep 1 2 3 4 5

Energy level 1 2 3 4 5

Exercise habits 1 2 3 4 5

Fluid intake 1 2 3 4 5

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours per week on average? \_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­\_\_\_\_\_\_

How do you spend most of your work day?

❏ Sitting ❏ Sitting w/ mostly computer work ❏ Standing

❏ Light manual labor ❏ Manual labor ❏ Hard Manual Labor

Current Stress Level: ❏ Constant ❏ Moderate ❏ Mild ❏ None

**Other Health History**

**Do you have any other underlying or pre-pregnancy health complications:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**List any hospitalizations, major accidents, major illnesses and surgeries (include approximate DATES):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**List all medications, vitamins, minerals, or supplements you are taking:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**List all known allergies (including medications, foods, seasonal, oils/lotions, scents etc.):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever received massage therapy before?** ❏ No ❏ Yes (Date of last massage:\_\_\_\_\_\_\_\_\_\_\_\_)

**Consent for Care** I hereby state that the above information that I have filled in is true and accurate to the best of my knowledge. I

authorize my massage therapist to communicate with my Medical Doctor or Prenatal Healthcare Provider as deemed necessary for my

treatment. I understand that my personal and medical information (both written and spoken) is confidential and will only be disclosed to

third parties with my permission. I also understand that I am expected to notify my LMP if there are any changes to my health/pregnancy

OR if I am uncomfortable with ANY part of my massage therapy treatments. I am aware that I need to consult with my Prenatal

Healthcare Provider PRIOR to receiving massage therapy if I am a high risk pregnancy or am experiencing any contraindicated conditions

in which it would be inadvisable for me to receive massage. I understand that I will be receiving massage therapy as an adjunctive form

of healthcare only, and that I must continue to receive appropriate medical care from my Prenatal Healthcare Provider.

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