Pre-Natal Massage Intake Form *Mei Leslie, LMT, CST-T*
Selah Massage & Bodywork

Client Information

Name _____ Date _____

Address _____ City, State & Zip _____

Phone_____(Circle: Cell / Home / Work) Email _____

I prefer to receive appointment reminders via: ❑ Text ❑ Phone call/Voice mail ❑ Email

Birthday_____/_____/_____ Age _____Occupation_____

Emergency Contact _____ Phone _____

Primary Physician / Ob/Gyn

Name_____ Phone_____

Address_____

❑ Yes ❑ No I give my massage therapist permission to consult with my health care providers regarding my health and treatment, if needed.

Pregnancy Information / History

Gestational weeks _____ Due date _____

How many previous pregnancies? _____ If more than 0, any premature births? ❑ Yes ❑ No

When did you last feel fetal movement? _____

List activities/exercises you do regularly: _____

Have you had previous professional massage / bodywork? ❑ Yes ❑ No / Pre-natal Massage? ❑ Yes ❑ No

*Please **check** any that you have had or are experiencing:*

- ❑ heavy discharge
- ❑ vaginal bleeding / spotting
- ❑ unusual abdominal pain
- ❑ preclampsia / high blood pressure
- ❑ morning sickness
- ❑ deep vein thrombosis (DVT)
- ❑ swollen ankles
- ❑ varicose veins
- ❑ sciatica
- ❑ diabetes: ❑ type 1 ❑ type 2 ❑ gestational

Medical History *(Check any that apply)*

- ❑ arthritis
- ❑ asthma
- ❑ cancer
- ❑ carpal tunnel syndrome
- ❑ chronic pain
- ❑ dizziness/vertigo
- ❑ epilepsy
- ❑ fainting
- ❑ fibromyalgia
- ❑ headaches
- ❑ heart disease
- ❑ hepatitis
- ❑ HIV / AIDS
- ❑ infectious conditions
- ❑ kidney ailments
- ❑ lung/respiratory ailments
- ❑ multiple sclerosis
- ❑ muscular dystrophy
- ❑ neck/spine injury
- ❑ osteoporosis
- ❑ phlebitis
- ❑ PMS syndrome
- ❑ psoriasis / eczema
- ❑ scoliosis
- ❑ skin conditions
- ❑ sports injury
- ❑ tendonitis
- ❑ ticklish
- ❑ TMJ syndrome
- ❑ tuberculosis
- ❑ ulcers
- ❑ other _____

List any hospitalizations, surgeries, bone fractures, joint replacements, accidents you have had, or conditions not listed above:

_____

_____

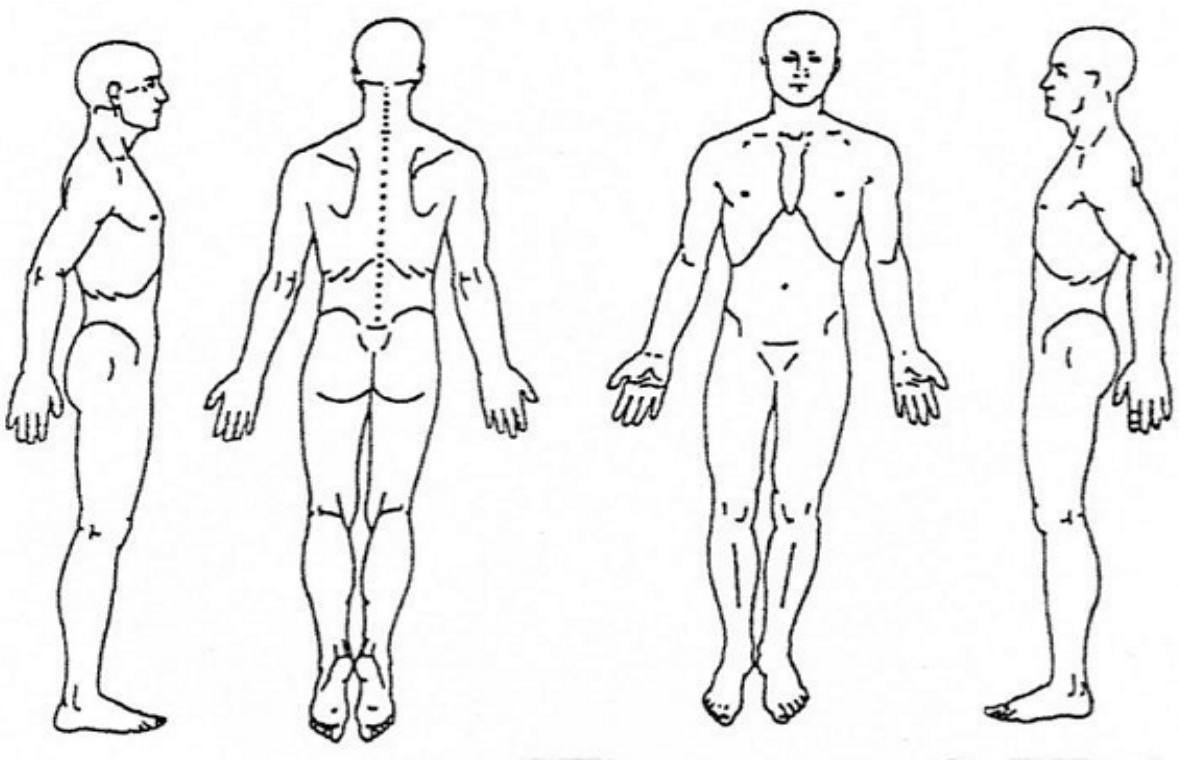
Current Health Information

Daily water intake: _____ 16 oz glasses

How would you describe your overall level of stress? ❑ Low ❑ Medium ❑ High

Are you currently in any pain? ❑ Yes ❑ No If yes, is it: ❑ Light ❑ Moderate ❑ Severe

On the figures below, please circle the area(s) needing attention today:



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Please read and sign:

I understand that pre-natal massage therapy is for the purpose of relaxation, stress reduction, and/or relief from muscular tension; and that the therapist does not diagnose illness, disease, or any other physical or mental disorder, or prescribe medical treatment or perform spinal manipulations. Information exchanged during the session is educational in nature and intended to help me become more conscious of my own health status. I have reported all my known medical conditions and agree to report any changes as they occur. I understand I have the right to refuse treatment at any time during the session. I consent to have therapeutic massage and do not hold the therapist liable for any action resulting in premature delivery or termination of this pregnancy.

Please note: If you have a specific medical condition or present specific symptoms, certain massage or bodywork techniques may be contraindicated. A referral from your primary care provider may be required prior to your session. When no referral is provided the therapist reserves the right to refuse treatment.

Client Signature _____ Date _____

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