Touch Of Tranquility
MASSAGE

www.touchoftranquilitymassageaz.com

Pregnancy Massage Intake Form

Name: _____Birth Date: _____

Occupation _____

Emergency Phone Contact …… Name: _____ Phone: _____

Have you received massage therapy or bodywork before? ____Yes ____NO If so what kind? _____

How often? _____

Are you on any Medication? ____ Yes _____NO If Yes, please list: _____

Do you exercise? ____Yes ____NO If yes, how many times per week? _____ How long of a period? _____

Have you had any serious or chronic illness, operations, or traumatic accidents? ____YES ____ NO

If yes please explain: _____

_____

Please list any other conditions/symptoms you have had or are currently having: _____

Due Date: _____ Number of pregnancies _____Live Births _____ How far along(weeks): _____

Please check current problems with an X mark past issues with an O

____*Anemia*	____ *Sciatica*	____ *Leaking amniotic fluid*	____ *Preeclampsia*
____ *Pre-term labor (toxemia)*	____ *Uterine bleeding*	____ *Twins or more*	____ *Separation of the rectus muscles*
____*Leg cramps*	____ *Bladder infection**	____ *Blood clot or phlebitis**	____ *Separation of the symphysis pubis*
____ *Miscarriage**	____ *Skin disorders/ athlete's foot*	____ *Problems with placenta**	____*Carpal tunnel syndrome*
____ *Allergy to nut oils*	____*Chronic hypertension*	____ *Varicose veins*	____ *Hypo or hyperglycemia*
____*abdominal cramping**	____ *Visual disturbance*	____ *Diabetes (gestational or melli*	____ *Nausea*
____ *Previous cesarean birth*	____ *Edema/swelling*	____ *Contagious conditions*	____ *Low blood pressure*
____*Fatigue*	____ *Muscle sprain/ strain*	____ *Headache*	____ *High blood pressure*
____ *Heart attack/stroke*	____ *Insomnia*	____ *Arthritis/bursitis_*	

____ *Other conditions or problems in current or past pregnancy*_____

_____

Please read and understand fully before signing

Type of Pregnancy: (Circle One) *Low Risk* *High Risk*

*I am experiencing a low risk (specified above) pregnancy according to my doctor/midwife. If I am currently having or develop complications (any symptoms/ conditions listed above with *) I will discuss the condition with my massage therapist 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 heath aid and does not take the place of a physician's care. Any information exchanged during a massage or bodywork session is confidential and is only used to provide you 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.*

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance. If I am late for my appointment, I understand that I will pay the full fee for the time allotted me.

Signature: _____ *Date :* _____