**Om nirvana therapeutic massage**

Pregnancy Massage Client Intake Form

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency phone contact: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you learn about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you received massage therapy or bodywork before?\_\_\_\_\_\_\_\_\_\_\_\_\_What kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you on any medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, what:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you exercise\_\_\_\_\_\_\_\_\_ How many times per week:\_\_\_\_\_\_\_\_ For how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please list and explain other conditions/symptoms you are or have experienced:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had any serious or chronic illness, operations, or traumatic accidents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prenatal Care Provider/Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I have permission to contact your care provider?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My due date is\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ This is my \_\_\_\_\_\_\_\_\_\_\_(1st, 2d, etc.) pregnancy. This will be my \_\_\_\_\_\_\_\_\_\_\_(number 1st, 2d …) birth. I am\_\_\_\_\_\_\_\_\_\_(number) weeks pregnant in my \_\_\_\_\_\_\_\_\_(1st, 2d, 3d) trimester Pregnancy Massage Client Intake Form Please check current problems (X), mark with (+) if you had in the past: \_\_\_anemia \_\_\_sciatica \_\_\_leaking amniotic fluid\* \_\_\_separation of the rectus muscles \_\_\_bladder infection\* \_\_\_separation of the symphysis pubis \_\_\_uterine bleeding \_\_\_skin disorders/athletes foot \_\_\_blood clot or phlebitis\* \_\_\_twins or more !\* \_\_\_chronic hypertension \_\_\_varicose veins \_\_\_abdominal cramping\* \_\_\_visual disturbances\* \_\_\_diabetes (gestational or mellitus) \_\_\_previous cesarean birth \_\_\_edema/swelling \_\_\_contagious conditions \_\_\_fatigue \_\_\_muscle sprain/strain \_\_\_headaches \_\_\_heart attack/stroke \_\_\_insomnia \_\_\_arthritis \_\_\_high blood pressure \_\_\_carpal tunnel syndrome \_\_\_leg cramps \_\_\_allergy to nut oils \_\_\_miscarriage\* \_\_\_low blood pressure \_\_\_nausea \_\_\_bursitis \_\_\_problems with placenta\* \_\_\_hypo or hyperglycemia \_\_\_pre-term labor \_\_\_contact lens \_\_\_preeclampsia (toxemia)\* \_\_\_allergies (i.e., peanut oil) \_\_\_other conditions or problems in current or past pregnancy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anything else you would like for me to know:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I am experiencing a low risk/high risk (circle one) 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, and will have a medical release for bodywork signed by my prenatal care provider 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 health 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. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_