

Cary Massage

Pregnancy Massage Intake Form

Date: _____

Name: _____ Birthday: ___/___/___

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

Date of first massage appointment _____

Expected due date _____

Number of pregnancies _____

Number of births _____

Pre-natal care provider _____

Have you ever experienced a therapeutic massage before? _____

Have you experienced pregnancy massage before? _____

Are you currently taking any medications? _____ If so what are they? _____

Have you taken any medications prior to this pregnancy? _____

Do you currently have any areas of discomfort? _____

Do you have any past injuries or surgeries that I should know about? _____

What is your current occupation? _____ Does it involve long periods of (circle all that apply): sitting/standing/computer terminal work/telephone work/other _____?

When do you plan to begin maternity leave? _____

Do you have any history of: (please check any that apply)

_____ high blood pressure	_____ pre-term labor
_____ low blood pressure	_____ thyroid problems
_____ edema	_____ headaches
_____ morning sickness/nausea	_____ sinus congestion
_____ heartburn	_____ constipation
_____ hemorrhoids	_____ diarrhea
_____ varicose veins	

I do hereby understand that the services offered are not a substitute for medical care, and any information provided by the therapist is for educational purposes only. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

Client Signature

Date