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
_____low blood pressure
_____edema
_____morning sickness/nausea
_____heartburn
_____hemorrhoids
_____varicose veins
_____pre-term labor
_____thyroid problems
_____headaches
_____sinus congestion
_____constipation
_____diarrhea

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