PRE-NATAL MASSAGE

NAME: _____ **BIRTHDAY:** _____

ADDRESS: _____
CITY STATE ZIP

EMAIL: _____ **PHONE #:** _____

EMERGENCY CONTACT NAME: _____ **PHONE #:** _____

HOW DID YOU HEAR ABOUT US? _____
(IF REFERRED BY ANOTHER CLIENT, PLEASE PROVIDE THEIR FIRST AND LAST NAME)

MEDICAL HISTORY

What discomforts, pain, or other needs are you hoping to have addressed through this massage therapy?

In what week of your pregnancy are you? _____

Are you regularly seeing a physician, nurse-midwife, or midwife? ☐ Yes ☐ No

Please indicate if any of the following apply to you:

☐ Bleeding	☐ Protein in urine	☐ Abnormal fetal growth
☐ Cramping amniotic fluid leakage	☐ High blood sugar	☐ Water retention
☐ Vision disturbances	☐ Heartbeat or movements	☐ High Blood Pressure
☐ Severe nausea	☐ Rapid weight gain	☐ Vomiting
☐ Headaches	☐ Other: _____	

Do you have any medical conditions?

☐ Diabetes	☐ Heart	☐ Liver
☐ Kidney	☐ Lung disease or disorders	☐ Uterine abnormality
☐ Other: _____		

Are you currently experiencing any of the following?

☐ Cold	☐ Bladder infection	☐ Skin irritations
☐ Varicose veins	☐ Other: _____	

High Risk Pregnancies: Diabetes, hypertension, multiple pregnancy, previous complicated pregnancy, asthma, Rh factor or genetic problems, under the age of 20 or over the age of 35.

Is your pregnancy considered to be high risk? ☐ Yes ☐ No

BY SIGNING BELOW, I CERTIFY THAT THE INFORMATION PROVIDED ABOVE ARE COMPLETE, ACCURATE, AND UP TO DATE TO MY KNOWLEDGE.

SIGNATURE: _____ **DATE:** _____

PRE-NATAL MASSAGE

CONTRAINDICATIONS

Massage therapy during pregnancy has been shown to be beneficial for a number of common complaints such as fatigue, musculoskeletal pain, sciatica, edema, and many others. However there are risks associated with specific conditions that may occur during pregnancy.

You must inform your massage therapist if you have or have had in the past any of the following conditions or symptoms which may make massage therapy during pregnancy contraindicated or may require your therapist to alter the massage.

- History of miscarriage
- Gestational Diabetes
- Cardiac, pulmonary, liver, or renal disorders
- Mother's age under 20 or over 35
- Pitting edema
- Epilepsy or other convulsive disorders
- Placental or cervical dysfunction
- Abdominal pain
- Leaking of amniotic fluid
- Fever
- Sudden edema/swelling
- Severe headaches
- Preeclampsia
- History of any high-risk pregnancy
- Drug exposure
- Multiples
- Hypertension
- Genetic abnormalities
- Fetal growth retardation
- Bloody discharge
- Sudden weight gain
- Diarrhea
- Decrease in fetal movement over 24-hours
- Severe nausea or vomiting

CLIENT'S RELEASE

I have read the aforementioned conditions and symptoms which make massage therapy during pregnancy contraindicated. The massage therapist has discussed this information with me and provided opportunity for any questions. I have disclosed all high-risk factors of my pregnancy.

I have discussed with my prenatal healthcare provider/physician any health concerns that I had about receiving massage therapy. I agree that my healthcare provider/physician has given me clearance to receive massage therapy.

I understand the information contained on this form and confirm that (1) I am receiving medical care including regular check-ups with a licensed healthcare provider. (2) I have not experienced any of the listed symptoms, conditions, or complications. (3) I am not *currently* experiencing any of the listed symptoms, conditions, or complications. (4) I am experiencing a low-risk pregnancy.

I understand that I will be receiving massage therapy as an adjunct form of healthcare only and that this therapy is not meant to replace appropriate medical care. I release the massage therapist and the staff of Remedi Elite Day Spa LLC of all liability for any harm that may unintentionally occur during my treatment(s).

SIGNATURE: _____ **DATE:** _____