



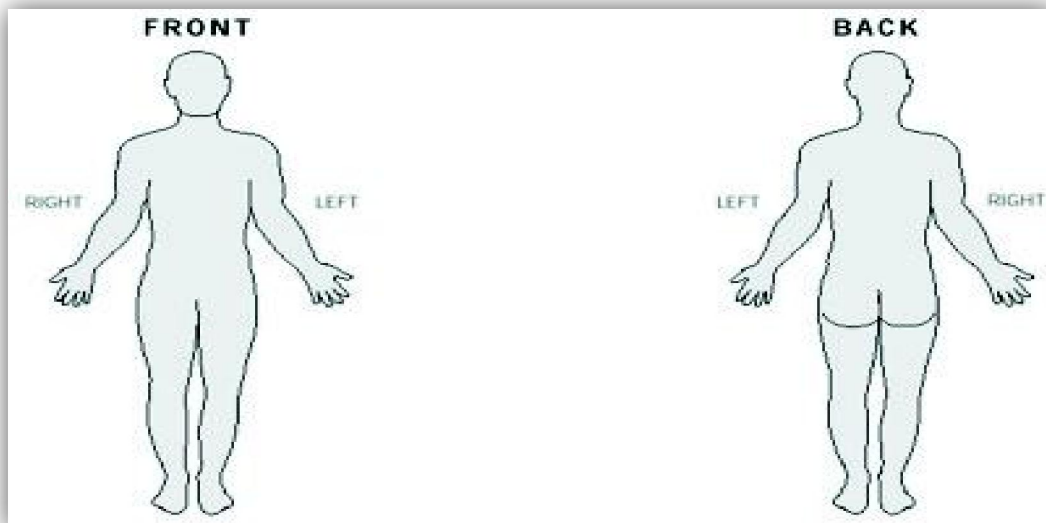
## Pregnancy Massage Medical History Form

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Emergency Contact / Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Have you ever had pregnancy massage? \_\_\_\_\_  
Obstetrician name and number: \_\_\_\_\_  
Surgical History: \_\_\_\_\_  
Medications: \_\_\_\_\_  
Which trimester are you in: \_\_\_\_\_ Due Date: \_\_\_\_\_ How many pregnancies have you had: \_\_\_\_\_  
Do you have any tension or soreness in a specific area? Please specify: \_\_\_\_\_  
Referred by (so we know who to thank): \_\_\_\_\_

**Please check appropriate boxes and explain as clearly as possible.**

- |   |   |
|---|---|
| <input type="checkbox"/> Over 36 years old                | <input type="checkbox"/> Heartburn                                |
| <input type="checkbox"/> First Pregnancy                  | <input type="checkbox"/> Bladder/Kidney infection                 |
| <input type="checkbox"/> Gestational Diabetes             | <input type="checkbox"/> Current infectious / contagious diseases |
| <input type="checkbox"/> Frequent headaches or migraines  | <input type="checkbox"/> Muscle cramps                            |
| <input type="checkbox"/> Placental dysfunction            | <input type="checkbox"/> Bruise easily or bleeding disorders      |
| <input type="checkbox"/> Swollen feet and /or hands       | <input type="checkbox"/> Uterine bleeding                         |
| <input type="checkbox"/> Blood Clots/Phlebitis            | <input type="checkbox"/> Abdominal Cramping                       |
| <input type="checkbox"/> High blood pressure              | <input type="checkbox"/> Preeclampsia (toxemia)                   |
| <input type="checkbox"/> Varicose Veins                   | <input type="checkbox"/> Miscarriages                             |
| <input type="checkbox"/> Suffer from epilepsy or seizures |   |

**Place an "X" over problem areas**





## PRENATAL MASSAGE THERAPY: CLIENT RELEASE FORM

I, \_\_\_\_\_ have received and read the attached written information about the possible contraindications to massage therapy during pregnancy, In addition, I have discussed with my physician and have had the opportunity to ask questions of the massage practitioner and of my physician about the information. I understand the information and confirm that:

- I have not experienced any of the complications listed on the attached sheet
  - I have not experienced any of the conditions listed, which would make it unwise to have massage therapy
  - I am experiencing a low-risk pregnancy
  - I am receiving medical care including regular check-ups throughout my pregnancy
- I understand that pregnancy massage I will be receiving here is for the purpose of stress reduction, relief from muscular tension or spasm and are non-sexual. I understand that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. I understand that massage is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical ailments that I may have.
- I acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. I understand that it is my responsibility to inform the massage therapist of any changes to this information and agree that there shall be no liability on the practitioners part should I fail to do so. I understand that if I experience any unusual discomfort and/or pain during my massage session it is my responsibility to inform the massage therapist so that they can adjust the pressure or technique being used.
- All written records and massage sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client . Unless legally required by local, state, or federal subpoena, summons, or court order.
- If I cancel or miss a scheduled appointment without 24-hours notice, a full visit fee for that appointment will be charged. Your appointment day/time is your responsibility as we do not do appointment reminder calls.**
- By signing this release I hereby waive Julie Barton of Optimum Wellness from all liability past, present, and future relating to massage and bodywork.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_