

Pregnancy Health Form

Name _____ Today's Date _____

#of Weeks Pregnant _____ Your Baby's Due Date _____

Name of your doctor or midwife _____
Phone # _____

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

2. Have you had any complications or problems with this pregnancy? Yes No

If yes, please check those which are applicable:

- Bleeding
- Cramping
- Amniotic fluid leakage
- Water Retention
- High Blood Pressure
- Rapid Weight Gain
- Uterine abnormality
- Convulsive disorder
- Heart, liver, kidney or lung disorder
- Other _____
- Protein in urine
- High Blood Sugar
- Vision Disturbances
- Severe Nausea
- Abnormal vomiting or headaches
- Abnormal fetal growth, heartbeat, movements
- Diabetes
- Connective tissue or collagen disease

3. Are you currently experiencing any infection or disorder? Yes No

If yes, please check those which are applicable:

- Cold
- Bladder Infection
- Other _____
- Skin irritation
- Varicose veins

4. Is your pregnancy considered high risk? Yes No

If yes, please check those which are applicable:

- Diabetes
- Hypertension
- Multiple Pregnancy
- Previous complicated pregnancy
- Asthma
- Rh or genetic problem
- Under 20 or over 40 years old
- Fetal genetic disorders
- Exposure to hazardous materials
- Other _____

5. Is there any other relevant information about this pregnancy or about you that I should know?

Please complete the release below and obtain healthcare provider's release.

MOTHER'S RELEASE

To Kate Katahdin (massage therapist)

I understand that I will be participating in massage therapy sessions as a form of adjunctive health care.

_____ My pregnancy is progressing normally. A provider release is optional.

_____ I am experiencing a prenatal complication or a high risk factor and will obtain a release from my prenatal health care provider prior to receiving massage therapy.

If there are any changes in my situation I will let the massage therapist know, so that we can determine if additional provider release is required.

My prenatal health care provider is _____

Phone: home _____ cell _____

(Signature) _____ (Date) _____

PRENATAL HEALTH CARE PROVIDER'S RELEASE FOR
THERAPEUTIC MASSAGE/BODYWORK DURING PREGNANCY

_____ (patient) has requested prenatal therapeutic massage. These services are provided as adjunctive health care. When an individual's pregnancy is high risk, or she has experienced complications or contraindicated conditions, it is our policy to work with her only if her maternity healthcare provider has reviewed this request. Please verify your clearance of this request by your signature below. Please also list any precautions or limitations which you feel to be appropriate. Thank you for your assistance.

Limitations: _____

(Signature) _____, prenatal health care provider

Phone: _____ (Date) _____