TRUE ESSENCE
TRANQUILITY

PRENATAL MASSAGE FORM

Name: _____ Birthdate: ____/____/____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Emergency Contact #: _____ Name/Relation to you: _____

Name of Obstetrician/Midwife: _____ How many weeks are you? _____

How do you prefer to be contacted? ☐ Cell ☐ Home ☐ Work ☐ Email ☐ Facebook

Who referred you / how did you hear about us? We would like to thank them! _____

May we contact your place of business for promotional opportunities / chair massages? ☐ Yes If yes, who is your employer?

_____

Please describe how you have felt (physically and emotionally) during this pregnancy:

_____

_____

Have you had any complications or abnormalities? ☐ Yes ☐ No If yes, please describe:

_____

If yes, do you have the permission of your physician or midwife to receive a massage? ☐ Yes ☐ No

Would you like your abdomen massaged? ☐ Yes ☐ No

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge….

Have you had professional massage / Reiki before? ☐ Yes ☐ No

If yes, how often do you receive? _____

Do you have any allergies to oils, lotions or ointments? ☐ Yes ☐ No

If yes, please explain:

_____

Do you have sensitive skin? ☐ Yes ☐ No Are you wearing ☐ contact lenses ☐ dentures ☐ a hearing aid? ☐ None

Do you sit for long hours driving, or sitting at a workstation or computer? ☐ Yes ☐ No If yes, please describe:

_____

Do you perform repetitive movement in your work, sports or hobby? ☐ Yes ☐ No If yes, please describe:

_____

Do you experience stress in your work, family or other aspect of your life? ☐ Yes ☐ No

If yes, how do you think it has effected your health?
☐ Muscle tension ☐ Anxiety ☐ Insomnia ☐ Irritability ☐ Other

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? ☐ Yes ☐ No

If yes, please identify: _____

What goals do you have in mind for this session? _____

MEDICAL HISTORY

In order to plan a session that is safe and effective, we need some general information about your medical history.

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please list: _____

Please check any condition listed below that applies to you:

☐ contagious skin condition
☐ open sores or wounds
☐ easy bruising
☐ recent accident or injury
☐ recent fracture
☐ recent surgery
☐ artificial joint
☐ sprains / strains
☐ current fever
☐ swollen glands
☐ headaches / migraines
☐ allergies / sensitivity
☐ heart condition
☐ high or low blood pressure
☐ circulatory disorder
☐ varicose veins
☐ atherosclerosis
☐ phlebitis
☐ deep vein thrombosis / blood clots
☐ joint disorder / rheumatoid arthritis
☐ osteoarthritis / tendonitis
☐ osteoporosis
☐ epilepsy
☐ cancer
☐ diabetes
☐ decreased sensation
☐ back / neck problems
☐ fibromyalgia
☐ TMJ
☐ carpal tunnel syndrome
☐ tennis elbow

Do you have any of the following conditions or symptoms associated with your pregnancy?

☐ pre-term labor
☐ fever
☐ abdominal pain
☐ excessive swelling of limbs
☐ decreased fetal movement (past 24 hours)
☐ toxcimia / preeclampsia
☐ vaginal bleeding / abnormal discharge
☐ diarrhea
☐ previous miscarriages

The above conditions are contraindicated for massage; if you marked any of them, your therapist may need the approval of your physician to continue, or may not be able to work on you at this time.

Draping will be used during the session. Only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent of legal guardian during the entire session. Informed, written consent must be provided by parent or legal guardian for any client under the age of 17.

The above information is accurate and true to the best of my knowledge. I understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for updating my practitioner to any physical, mental or emotional changes that occur with my health during my pregnancy. I agree that I am seeking massage voluntarily for treatment of mild discomfort.

Signature: _____ Date: _____

Signature of Therapist _____ Date _____