CONFIDENTIAL CLIENT INFORMATION FORM
Pregnancy Massage

Name: _____ Phone Number: _____

Address: _____ City, State, Zip_____

Birthday: _____ E-mail: _____ Due Date: _____

☐ Check the box to NOT be signed up for The Metta Center's monthly e-newsletter

Emergency Contact Number: _____ Emergency Contact Name: _____

Who can we thank for referring you? (Specify friend, website or other source) _____

Prenatal Care Provider_____ Telephone # _____

I am in my _____ (1st, 2nd, 3rd) trimester. This is my _____ pregnancy. I have had _____ losses.

Do you have any of the following? (Please check mark all that apply)

___ Anemia	___ Leaking amniotic fluid	___ Bladder infection	___ Uterine bleeding	___ Sciatica
___ Blood Clot	___ Chronic Hypertension	___ Skin Disorders	___ Back Pain	___ Gestational Diabetes
___ Fatigue	___ High/Low Blood Pressure	___ Insomnia	___ Headaches	___ Leg Cramps
___ Edema	___ Abdominal Cramping	___ Nausea	___ Varicose Veins	___ Arthritis
___ Bursitis	___ Thyroid Problems	___ Muscle Sprain	___ Carpal Tunnel	___ Constipation
___ Diarrhea	___ Pre-term labor	___ Hemorrhoids	___ Heartburn	___ IUI/IVF (circle)
___ Fibroids	___ Anterior Placenta	___ Placenta Previa	___ with Multiples	___ DVT

If you checked any of the above, please explain further here. _____

_____

Other Conditions current or in past pregnancies not listed: _____

_____

List any past accidents and surgeries: _____

List any medications that you are taking and what they are for: _____

_____

Office Use Only: ☐ Vagaro: General Info ☐ Vagaro: Health History ☐ Added to Mailchimp ☐ Referral email sent ☐ Scanned to computer

What is your current occupation? _____

Does it involve long periods of (circle all that apply): Sitting, Standing, Computer Work, Telephone Work, or

Other_____

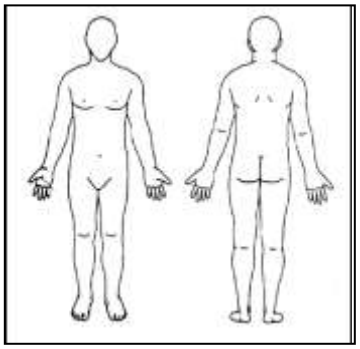
When do you plan to begin maternity leave? _____

MASSAGE BACKGROUND

Have you ever received a professional massage? _____ If yes, what type: _____
Are you allergic/sensitive or dislike any oils or creams? ____ If yes, what type: _____

Mark areas of pain with an X
Mark where you had surgery with an O

List specific areas of the body for Pain Relief work:
_____



Depth of pressure preferred (circle): Light Medium Strong Extra Strong

*Therapeutic Massage may include work on the scalp, face, feet, and glutes. (Abdominal and/or Breast Massage is only performed on request)

List any areas of the body that you would prefer not to be worked on:
_____

Please initial in the following paragraph:

I am experiencing a **low risk/high risk (please circle one)** pregnancy according to my doctor/midwife. If I am currently having or develop complications I will discuss the condition with my massage therapist. I will receive permission from my prenatal provider if any further complications arise. I will immediately let my therapist know of any pain or discomfort I feel so that pressure and strokes can be adjusted to my level of comfort. ___(Initial)

I understand that therapeutic massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment. Because therapeutic massage/bodywork should not be performed under certain circumstances, I affirm that I have stated all medical conditions of which I am aware and will inform my practitioner of any changes in my medical status. ___(Initial)

If I am unable to make a scheduled appointment, I agree to cancel before 4:00 PM the day before my scheduled appointment. If I do not cancel before 4:00 PM the day before, I agree to the cancellation policy and subsequent fee. ___ (Initial)

Signature: _____ Date: _____