

DYNAMIC MASSAGE & BODYWORK

572 Westgate Pkwy

Dothan AL 36305 (334) 69-6832

PREGNANCY MASSAGE THERAPY INTAKE AND HEALTH HISTORY

Name _____ Phone _____ Date _____

Address _____

Date of Birth ____/____/____ Referred by _____

Occupation _____ Exercise Activities _____

1. What discomforts, pain or other needs are you hoping to have addressed through massage therapy?
2. What is your due date and in what week of pregnancy are you?
3. Who is your healthcare provider?
4. Have you had any complications or problems with this pregnancy?

Abnormal Fetal Growth	Cramping	Rapid Weight Gain
Abnormal Fetal Heartbeat	Headaches	Sever Nausea
Abnormal Fetal Movements	High Blood Pressure	Vision Disturbances
Amniotic Fluid Leakage	High Blood Sugar	Vomiting
Bleeding	Protein in Urine	Water Retention
Other _____		

5. Do you have any of the following medical conditions?

Diabetes	Kidney Disease	Lung Disease
Heart	Liver Disease	Uterine Abnormality
Other _____		

6. Are you currently experiencing any infection or disorder?

Cold	Bladder Infection	Varicose Veins
Other _____		

7. Is your pregnancy considered to be high risk?

Asthma	Multiple Pregnancy	Rh or Genetic Problems
Diabetes	Previous Complicated Pregnancy	
Hypertension	Under 20 or over 35 years old	

8. Is there anything else relevant about this pregnancy or about you that I should know?

The above information is correct to my knowledge. I understand that massage therapists do not diagnose or treat disease. I take responsibility for alerting my therapist of any changes to my health status before each session, as well as any and all responses perceived to be a result of massage therapy as soon as I become aware of them. I hereby freely give my permission to be massaged.

Signature _____ Date _____