Healthy Motions® Massage Therapy

702 K St. NE- Lower Level
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CONFIDENTIAL CLIENT INFORMATION FORM – Pregnancy Massage

Name:____ Date of Birth (Age):______________

Address: ____

Phone Number(s): (h)________________ (w) __________________ (c) ________________

E-mail:________________________ How did you hear about us?________________________

Week of Pregnancy : ________ Expected Due Date:_______ Health Care Provider: ______________

Occupation: ____________________________

What stress reduction/exercise activities do you engage in and how often? ________________

Please check any condition or complication you may have experienced in this pregnancy:

_____ Gestational diabetes*
_____ Threatened Miscarriage*
_____ Premature Labor*
_____ Placental dysfunction (placenta previa or abruptio)*
_____ Incompetent cervix*
_____ Pre-eclampsia/Pregnancy-Induced Hypertension (PIH)/Toxemia*
_____ Eclampsia*
_____ Heart Disease or Heart Condition*
_____ High blood pressure
_____ Multiple Pregnancy (twins, etc.)
_____ Bladder Infection

_____ Leg cramps
_____ Restless legs
_____ Headaches
_____ Heartburn
_____ Swollen Hands and/or Feet
_____ Varicose veins
_____ Phlebitis
_____ Indigestion
_____ Constipation
_____ Hemorrhoids
_____ Difficulty sleeping

**Medical release required prior to massage treatment*

Comments:____

Please list any past accidents and surgeries:__________________________________

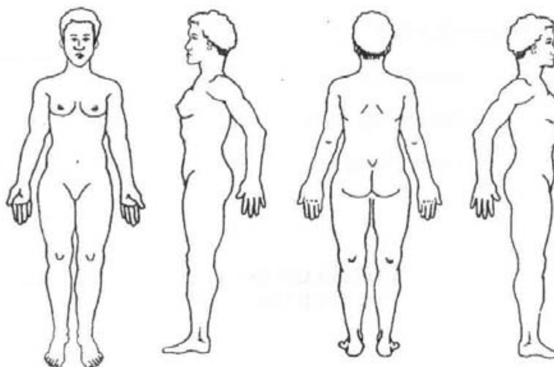
Please list any medications that you are taking: ______________________________

Have you ever received professional massage? __________ If yes, approximate number received:__________

Are you allergic/sensitive to any oils or creams? __________ If yes, what type:________________

Therapeutic massage is non-sexual and typically includes work on the muscles of the scalp, face, abdomen, feet, and glutes. Please list any areas of the body that you would prefer not be worked on:________________

On the figures, mark areas of
pain/tenderness/soreness with **P**'s
numbness/tingling with **Z**'s
swelling/stiffness with **S**'s:



Is there any area on which you particularly want to focus in your massage session? ________________
Is there anything else you want me to know about your health or pregnancy? ________________

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.

Signature: ______________________________ Date: __________________