



702 K St. NE- Lower Level
 Main No./Kevin: 202-246-4738
 Granetta: 202-276-0517

Healthy Motions® Massage Therapy

CONFIDENTIAL CLIENT INFORMATION FORM – Pregnancy Massage

Name: _____ Date of Birth (Age): _____

Address: _____

Phone Number(s): (h) _____ (w) _____ (c) _____

E-mail: _____ Yes. Please send me email newsletters with special offers.

Week of Pregnancy : _____ Expected Due Date: _____ Health Care Provider: _____

Occupation: _____ How did you hear about us? _____

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:

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Gestational diabetes*
<input type="checkbox"/> Threatened Miscarriage*
<input type="checkbox"/> Premature Labor*
<input type="checkbox"/> Placental dysfunction (placenta previa or abruptio)*
<input type="checkbox"/> Incompetent cervix*
<input type="checkbox"/> Pre-eclampsia/Pregnancy-Induced Hypertension (PIH)/Toxemia*
<input type="checkbox"/> Eclampsia*
<input type="checkbox"/> Heart Disease or Heart Condition*
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Multiple Pregnancy (twins, etc.)
<input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Leg cramps
<input type="checkbox"/> Restless legs
<input type="checkbox"/> Headaches
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Swollen Hands and/or Feet
<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Indigestion
<input type="checkbox"/> Constipation
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Difficulty sleeping |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*Medical release required prior to massage treatment

Comments: _____

Please list any past accidents and surgeries: _____

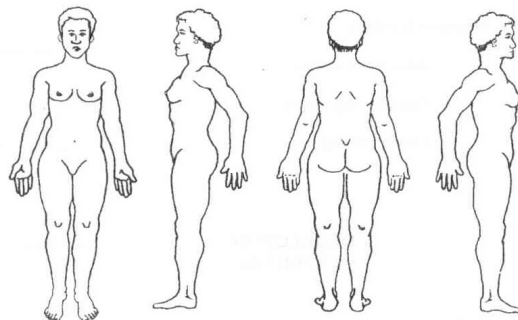
Please list any medications that you are taking: _____

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: _____