Pre Natal Massage Intake Form

Welcome and Congratulations! We want to take the very best care of you and your baby, so relax and enjoy your treatment with our fully capable NYS Licensed Therapist.

Name:____ Date: __________________

Address:____

E-mail: ____

Phone: ___________________________ Date of Birth:_________________________

OBGYN Doctor: _______________________________ Phone: ___________________

Emergency Contact Information:

Name: __________________________________ Relation: _____________________

Phone: ________________________________

How many weeks/ months into the pregnancy are you? ______________________

With this pregnancy or any other, have you had any of the following?

- Placenta Previa
- Spotting
- Braxton Hicks
- Gestational Diabetes
- Allergies
- Sciatica
- Contagious skin rash
- Recent accident
- PreClampia
- Cramping
- High Blood Pressure
- Varicose Veins
- Seizures
- Migraine headaches
- Melanoma/ hyperpigm entation
- Extreme swelling
- Blood clotting
- Cold/Flu
- Bruise Easily
- Aneurysm

Does your Doctor consider you high risk?_____ If yes, why? ___________________

Have you had any miscarriage(s)? ______ If yes, when? _______________________

Signature: _____________________________________ Date: ___________________________