Spring Lake Massage Therapy & Wellness Center

1375 Regents Blvd. #202 :: Fircrest, WA 98466 :: 253-878-0174 O :: 253-442-6174 F

Intake & Consent Form for Prenatal Massage Therapy

Name: ___________________________________Birth Date: ______ /_____/______

Address:____(street, city, state, zip)

Phone #: __________________________ (h) (w) (cell) E-mail address: ____________________________________

Emergency Contact: __________________________ Relation: ____ ___________ Phone #: ___________________

Regular Medical Doctor: ____

Prenatal Healthcare Provider: ____❏Doula ❏Doctor ❏Midwife

Pregnancy Information

I have had ______ previous pregnancies and ______ previous births. I'm carrying ❏ one baby ❏ twins or more

Estimated Due Date: _______________ I am having a ❏boy ❏girl ❏surprise ~ Baby's Name: __________________

Have you ever experienced any of the following? ❏ Miscarriage ❏ Ectopic pregnancy ❏ Stillbirth

Previous Births

Most Recent <--- to ---> Least Recent

Birth date:					
Cesarean birth:	❏	❏	❏	❏	❏
< 38wks premature:	❏	❏	❏	❏	❏
Birth was induced:	❏	❏	❏	❏	❏

Pregnancy Related Conditions

Please indicate any pregnancy related conditions you have experienced either in this current pregnancy (check "C" box) or in any past pregnancies (check "P" box):

C - P	C - P	C - P	C - P
❏ ❏ Preterm Labor	❏ ❏ Headaches/Migraines	❏ ❏ Leg Cramps	❏ ❏ Dizziness/Fainting
❏ ❏ Pre-Eclampsia	❏ ❏ Sinus Concerns	❏ ❏ Pain in Pubic Bone	❏ ❏ Anemia
❏ ❏ Gestational Diabetes	❏ ❏ Swelling (Edema)	❏ ❏ Round Ligament Pain	❏ ❏ Hyperemesis
❏ ❏ Uterine Abnormalities	❏ ❏ Varicose Veins	❏ ❏ Sciatica	❏ ❏ Morning Sickness
❏ ❏ Hypertension, High BP	❏ ❏ Vulvar Varicosities	❏ ❏ Carpal Tunnel Pain	❏ ❏ Restricted Breathing
❏ ❏ Placental Dysfunction	❏ ❏ Hemorrhoids		
❏ ❏ IUGR/SGA			

Lifestyle & Occupation

Please circle the answer closest to how you presently feel (1 = poor, 5 = excellent):

Quality of sleep	1	2	3	4	5
Energy level	1	2	3	4	5
Exercise habits	1	2	3	4	5
Fluid intake	1	2	3	4	5

Occupation: ____

How many hours per week on average? ____________________

How do you spend most of your work day?

❏Sitting ❏Sitting w/ mostly computer work ❏Standing

❏Light manual labor ❏Manual labor ❏Hard Manual Labor

Current Stress Level: ❏ Constant ❏ Moderate ❏Mild ❏ None

Other Health History

Do you have any other underlying or pre-pregnancy health complications?

____

____

____

List any hospitalizations, major accidents, major illnesses and surgeries (include approximate DATES):

List all medications, vitamins, minerals, or supplements you are taking:

List all known allergies (including medications, foods, seasonal, oils/lotions, scents etc.):

Have you ever received massage therapy before? ❏ No ❏ Yes (Date of last massage: ____________________)

Additional Concerns You may have with your massage today:

____

Policies and Informed Consent:

If you need to reschedule your appointment, please give us AT LEAST 24 HOURS NOTICE so that we can fill the appointment space. If you do not show up for a scheduled appointment, you will be billed for 50% of the service(s) reserved.

Consent for Care:

- I hereby state that the above information is true and accurate to the best of my knowledge.
- I am aware that I need to consult with my Prenatal Healthcare Provider PRIOR to receiving massage therapy if I am a high risk pregnancy or am experiencing any contraindicated conditions.
- I have received authorization from my Prenatal Healthcare Provider to receive massage during the First Trimester and the risks have been explained to me. As such, I voluntarily release and agree to hold harmless Spring Lake Massage Therapy & Wellness Center and its massage therapist from any liability associated with the risks of massage during the First Trimester.
- I authorize my massage therapist to communicate with my Medical Doctor or Prenatal Healthcare Provider as deemed necessary for my well being and the well being of my baby.
- I understand that my personal and medical information (both written and spoken) is confidential and will only be disclosed to third parties with my permission.
- I also understand that I am expected to notify my LMP if there are any changes to my health/pregnancy OR if I am uncomfortable with ANY part of my session.
- I understand that I will be receiving massage therapy as an adjunctive form of healthcare only, and that I must continue to receive appropriate medical care from my Prenatal Healthcare Provider.
- By signing below, I agree that I have read the statements above and choose to receive a prenatal massage at my own risk.

Signature ____ Date____________