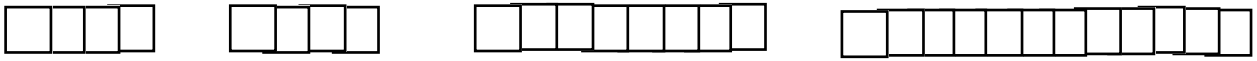

Kayleen Walsh
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Pre- and Perinatal Massage Therapy Health History Form

Name: _____ Phone:_____

Address: _____

Email: _____ Emergency Contact: _____

Today's date: _____ Birth Date: _____ Referred by: _____

1. What discomforts, pain, or other needs are you hoping to have addressed through treatments?

2. In what week of your pregnancy are you?

3. Are you regularly seeing a physician, nurse mid-wife, or midwife? Who? Phone number?

4. Have you had any complications or problems with this pregnancy?
Circle those that apply: bleeding, cramping, amniotic fluid leakage, water retention, high blood pressure, rapid weight gain, protein in urine, vision disturbances, severe nausea, vomiting, or headaches, abnormal fetal growth, heartbeat, or movements, high blood sugar, other:

5. Do you have any medical conditions? Circle those that apply: diabetes, heart, liver, kidney or lung disorders, convulsive disorders, uterine abnormally, connective tissue or collagen diseases, other:

6. Are you currently experiencing any infection or disorder? Circle those applicable: cold, bladder infection, skin irritation, varicose veins, other:

7. Is your pregnancy considered high risk? (Diabetes, hypertension, multiple pregnancies, previous complicated pregnancy, asthma, Rh or genetic problems, under 20 or over 35 years old, fetal genetic disorders, or exposure to hazardous materials)

8. Is there other relevant information about this pregnancy or about you that I should know? For example, any area you want me to avoid today or any position limitations?

_____ _____
PATIENT SIGNATURE DATE

PRE- AND PERINATAL WELCOME, BENEFITS, RELEASE FORMS, INTAKE