Intake and Health History Form

Name _____ Phone _____

Address _____

Today's date _____ Birthdate_____ Referred by _____

DUE DATE _____

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

2. In what week of your pregnancy are you?

3. Are you regularly seeing a physician, nurse-midwife, or midwife? Who?

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

5. Do you have any medical conditions? Circle those applicable: diabetes, heart, liver, kidney or lung disorders, convulsive disorders, uterine abnormality, 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, others:

7. Is your pregnancy considered to be high risk? (diabetes, hypertension, multiple pregnancy, 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?