Nurturing the Mother®

IN-TAKE FORM

Postpartum Massage

Name: _____

Phone (home):_____(work):_____

Address: _____

_____

Email: _____

Date of first massage appointment:_____

Delivery date: _____ Number of births: _____

Care provider:_____

Have you ever experienced a therapeutic massage before? ❑ Yes ❑ No

Did you receive a pregnancy massage? ❑ Yes ❑ No

Do you currently have any areas of discomfort? ❑ Yes ❑ No

If YES, what are they?_____

Do you have any past injuries or surgeries that I should know about? ❑ Yes ❑ No

Are you doing any form of exercise, such as yoga, walking, or swimming?_____

_____

When do you plan to return to your former occupation?_____

Did you experience any complications with your delivery? ❑ Yes ❑ No

If YES, explain: _____

_____

_____

_____

Do you have any history of, or are you currently experiencing (please check any that apply):

- ❑ High blood pressure
- ❑ Pre-term labor
- ❑ Low blood pressure
- ❑ Thyroid problems
- ❑ Edema
- ❑ Headaches
- ❑ Morning sickness/Nausea
- ❑ Sinus congestion
- ❑ Heartburn
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Varicose veins

**Disclaimer: We do not treat or prescribe within the context of our massage therapy session.*