

# Nurturing the Mother®



## IN-TAKE FORM

### Pregnancy Massage

Name: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (work): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

Date of first massage appointment: \_\_\_\_\_

Expected due date: \_\_\_\_\_

No. of pregnancies: \_\_\_\_\_

Number of births: \_\_\_\_\_

Pre-natal care provider: \_\_\_\_\_

Have you ever experienced a therapeutic massage before?  Yes  No

Have you ever experienced pregnancy massage before?  Yes  No

Are you currently taking any medications?  Yes  No

If YES, what are they? \_\_\_\_\_

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

What is your current occupation? \_\_\_\_\_

Does it involve long periods of (check all that apply):  Sitting  Standing

Computer terminal work  Telephone work  Other: \_\_\_\_\_

When do you plan to begin maternity leave? \_\_\_\_\_

Do you have any history of (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.*