

DR For Moms

CHIROPRACTIC CARE
THE LIFESTYLES WELLNESS GROUP

Prenatal Massage Health History

Name: _____ Birth Date: _____
Address: _____ Postal Code: _____
Home Phone: _____ Bus. Phone: _____
Occupation: _____ E-Mail (for massage discounts): _____
In Emergencies, Notify: _____ Phone: _____
Referred by: _____
Recreational Activities: _____

Health Care Provider

Medical Doctor: _____ Chiropractor: _____ Naturopath: _____
OB: _____ Midwife: _____ Doula: _____
Other Health Care: _____
Do you attend regular visits with your caregiver? *Y* *N*
When was your last appointment? _____
Has treatment been approved by your medical doctor? *Y* *N*

Health Questionnaire

Previous Injuries/Surgeries: _____
History of Cancer: *Y* *N* Type: _____
Have you ever had a prenatal massage before? *Y* *N*
Is this your first pregnancy? *Y* *N*
Are you experiencing any nausea? *Y* *N*
Are you presently taking any medications/ herbs/supplements?
Please list: _____
In what week of pregnancy are you? _____
When is your due date? _____
What discomforts, pain, or other needs are you hoping to have addressed through massage therapy?

Please check any complications or problems you have had with this pregnancy:

- | | |
|---|---|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> High Blood Sugar |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Protein in the Urine |
| <input type="checkbox"/> Amniotic Fluid Leakage | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Water Retention | <input type="checkbox"/> Severe Nausea |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vomiting or Headaches |
| <input type="checkbox"/> Rapid Weight Gain | <input type="checkbox"/> Abnormal Fetal Growth/ Heartbeat/ Movement |

Other: _____

Please check any applicable medical conditions:

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Uterine Abnormality |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Convulsive Disorders |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Connective Tissue or Collagen Disease |

Other: _____

Please check any infection or disorder that you may currently be experiencing:

- | | |
|--|--|
| <input type="checkbox"/> Cold/ Flu | <input type="checkbox"/> Skin Irritation |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Varicose Veins |

Other: _____

High Risk Pregnancies

Please check the following that may apply:

- | | |
|---|--|
| <input type="checkbox"/> Pre-pregnancy Diabetes Mellitus | <input type="checkbox"/> Age < 20 or > 35 |
| <input type="checkbox"/> Cardiac/ Pulmonary/ Renal or Liver Disease | <input type="checkbox"/> Drug or Hazardous Material Exposure |
| <input type="checkbox"/> Chronic Hypertension | <input type="checkbox"/> Rh- Mother or Genetic Problems |
| <input type="checkbox"/> Previous Problem Pregnancies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Multiple Pregnancies | <input type="checkbox"/> Convulsive Disorders |

Is there anything else relevant about this pregnancy or about you that I should know?

I hereby verify that I have stated all known medical conditions pertaining to my pregnancy, and the health history is accurate, complete, and current. I agree to advise the therapist of any changes or conditions that may arise which could be inadvisable for me to receive massage. I do forever release the massage therapist from any and all liability that may arise directly or indirectly out of my participation in massage therapy. All of the above information is strictly confidential and will not be disclosed without written consent of the client.

Cancellation policy: 24 hours notice is required for cancellation of appointments. As well, please be aware that in order to provide timely service to all of our clients, late arrival to an appointment will result in shorter treatment duration.

Client Name: (Please print) _____ Date: _____

Client Signature: _____