LAKEVIEW
EST · 2012
MASSAGE & THERAPY

Prenatal Concent Form

Name _____ Phone _____

Address _____

OB/Primary Care:_____Phone_____

Please complete this general information about your pregnancy/health history is helpful in planning a massage session that is safe and effective.

What week are you in this pregnancy? _____What is your due date? _____

What number pregnancy is this for you? _____How many children do you already have? _____

Are you currently taking any medications? ☐Yes ☐No

If yes, please list. _____

Please check any health condition listed below (or add) that applies to you in your past or present:

☐ History of miscarriage
☐ Gestational Diabetes
☐ Cardiac, pulmonary, liver, or renal disorders
☐ Sciatica Pain
☐ Pitting edema
☐ Epilepsy or other convulsive disorders
☐ Placental or cervical dysfunction
☐ Abdominal pain
☐ Leaking of amniotic fluid
☐ Fever
☐ Sudden edema/swelling
☐ Severe headaches
☐ Preeclampsia
☐ History of any high-risk pregnancy
☐ High/Low Blood Pressure
☐ Multiples
☐ Hypertension
☐ Genetic abnormalities
☐ Fetal growth issues
☐ Bloody discharge
☐ Sudden weight gain/loss
☐ Diarrhea
☐ Decrease in fetal movement over 24-hour period
☐ Severe nausea or vomiting
☐ Other _____

☐ I_____, understand that the massage I receive is provided for the purpose of relaxation and relief of muscular tension and stress. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

☐ I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor or other qualified medical professional for any mental or physical ailment that I am aware of.

☐ I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.

☐ I agree to keep the service provider or the therapist updated as to any changed in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Signature _____Date_____