



Personal Information

Name \_\_\_\_\_ Phone(Day) \_\_\_\_\_ Phone(Eve) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Please check (√) current problems, mark with (+) if you had in the past :

- |  |  |
|--|--|
| <input type="checkbox"/> anemia  | <input type="checkbox"/> sciatica                          |
| <input type="checkbox"/> leaking amniotic fluid *  | <input type="checkbox"/> separation of the rectus muscles  |
| <input type="checkbox"/> bladder infection *   | <input type="checkbox"/> separation of the symphysis pubis |
| <input type="checkbox"/> uterine bleeding *  | <input type="checkbox"/> skin disorders/ athletes foot     |
| <input type="checkbox"/> blood clot or phlebitis *                                       | <input type="checkbox"/> twins or more! *                  |
| <input type="checkbox"/> chronic hypertension *  | <input type="checkbox"/> varicose veins                    |
| <input type="checkbox"/> abdominal cramping *  | <input type="checkbox"/> visual disturbances *             |
| <input type="checkbox"/> diabetes (gestational or mellitus)                              | <input type="checkbox"/> previous cesarean birth           |
| <input type="checkbox"/> edema/swelling  | <input type="checkbox"/> contagious conditions             |
| <input type="checkbox"/> fatigue   | <input type="checkbox"/> muscle sprain / strain            |
| <input type="checkbox"/> headaches   | <input type="checkbox"/> heart attack / stroke             |
| <input type="checkbox"/> insomnia  | <input type="checkbox"/> arthritis                         |
| <input type="checkbox"/> high blood pressure *   | <input type="checkbox"/> carpal tunnel syndrome            |
| <input type="checkbox"/> leg cramps  | <input type="checkbox"/> allergy to nut oils               |
| <input type="checkbox"/> miscarriage *   | <input type="checkbox"/> low blood pressure                |
| <input type="checkbox"/> nausea  | <input type="checkbox"/> bursitis                          |
| <input type="checkbox"/> problems with placenta *  | <input type="checkbox"/> hypo or hyperglycemia             |
| <input type="checkbox"/> pre-term labor *  | <input type="checkbox"/> contact lens                      |
| <input type="checkbox"/> preeclampsia (toxemia) *  |  |
| <input type="checkbox"/> other conditions or problems in current or past pregnancy _____ |  |

Anything else you would like me to know? \_\_\_\_\_

I am experiencing a low risk / high risk (circle one) pregnancy according to my doctor/midwife. If I am currently having or develop complications (any conditions/symptoms listed above with \*) I will discuss the condition with my massage therapist, and will have a medical release for bodywork signed by my prenatal care provider before continuing bodywork.

I have completed this health form to the best of my knowledge. I understand that Bodywork is a health aid and does not take the place of a physician's care. Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services

Prenatal Care Provider/Doctor _____ Telephone _____
May I have permission to contact your Care Provider _____
My due date is _____.
This is my _____ (number 1 <sup>st</sup> , 2 <sup>nd</sup> , etc) pregnancy. This will be my _____ (number 1 <sup>st</sup> , 2 <sup>nd</sup> ...) birth.
I am _____ (number) weeks pregnant in my _____ (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> ) trimester.

Signature _____ Date _____
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