maryland licensed massage therapy

Pre-Natal Massage Therapy Health Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____

_____

Phone: (H) _____ (W) _____ (C) _____

E-mail: _____ How did you hear of us? _____

Expected due date: _____ Pre-natal care provider: _____

Phone: _____ Consent to exchange information with care provider: (Initials) _____

Number of Pregnancies: _____ Number of births: _____

Names and ages of children: _____

Please list all medications and supplements you are currently taking:

Please list all surgeries and/or injuries including approximate dates:

Do you currently have any areas of discomfort or pain? _____ If so, please specify:

Do you experience any difficulty lying on either your side or back? _____ If so, please specify:

Do you have any sensitivity to scented candles or oils?

Do you exercise regularly? _____ Please give a brief description including frequency and duration:

_____

Approximate number of hours of sleep per night: _____

Please rate the quality of your sleep on a scale of 1 to 5 (with 1 being extremely poor and broken sleep and 5 being restful sleep and waking refreshed): 1____ 2____ 3____ 4____ 5____

Please rate your recent stress level on a scale of 1 to 10 (with 1 being very low or manageable stress and 10 being very high or debilitating stress):

1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10____

Please continue on reverse side ➙

Located in Complete Care Acupuncture and Wellness
1641 Crain Hwy #203, Crofton, MD 21114
410.530.3089 | www.mdlmt.com

Please check if you are currently experiencing or have any history of the following conditions:

Pre-term Labor____	Easy Bruising____	Varicose Veins____
Pelvic Cramping____	Skin Sensitivity____	Phlebitis____
Miscarriage____	Open Sores____	Arteriosclerosis____
Fluid Retention____	IBS____	Hypertension____
Nausea____	Constipation____	Heart Disease____
Heartburn____	Rheum. Arthritis____	Epilepsy____
Headaches____	Osteoarthritis____	HIV/AIDS____
Migraines____	Osteoporosis____	Cancer____
Allergies____	Herniated Disc____	Diabetes____
Asthma____	Sciatica____	Fibromyalgia____
Sinusitis____	Limited ROM____	Anxiety____
TMJ Problems____	Carpal Tunnel Syn.____	Depression____

Details or any other relevant conditions: _____

_____

_____

Do you have any concerns regarding your current pregnancy? _____

_____

Have you experienced any complications with previous pregnancies or births? _____

_____

What is your occupation? _____ Start date of maternity leave: _____

Is this your first professional massage? _____ If not, when was your last massage? _____

What is your goal for today's session? _____

Would you like to receive information about our services and upcoming classes? _____

Information on this form will be treated confidentially and will be reviewed by massage therapists rendering your therapy in order to provide quality service.

*** I take responsibility for alerting my massage therapist on subsequent visits of any changes in my health or physical condition that might affect this work.**

*** I understand that Massage Therapy is a form of complimentary and alternative medicine as defined by the National Institute of Medicine.**

*** I understand that if I cancel within 24 hours of my scheduled appointment I will be charged the full amount due.**

Signature: _____ Date: _____

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