Prenatal Massage Therapy In-Take Form

Personal Information

Today's Date_____

Name _____ D.o.B_____

Address _____Email:_____

City _____ State_____ Zip _____

Best Telephone No. _____

Occupation or Occupational activities (e.g. heavy lifting, sitting, etc.)
_____D
o you exercise? _____How often?_____ What type?_____

How did you hear about me? _____

Medical History

What week of your pregnancy are you in? _____ Due Date _____

Health Practitioner's Name_____

Medications, supplements currently taking?_____
_____

Current Health Issues? (Please review list of contraindications to prenatal massage)_____

Is your pregnancy considered high risk? _____

Past surgeries? _____
_____

Any Allergies?_____

About Prenatal Massage

Have you ever had a prenatal massage? _____ Date of last treatment_____

If yes, was there anything you particularly liked/ disliked about it?
_____
_____

Are you currently experiencing any areas of tension/ pain in your body?
_____
_____

Any areas of your body you wish NOT to have massaged?_____

Is there anything else you feel would be helpful for me to know?

Rates & Policies

Massage/ Craniosacral Therapy
Initial Appts. minimum 90mins $140
General   60 minutes $100   75minutes $120   90 minutes $140

*Home Visits for massage are available only under extenuating circumstances such as bed rest, hospital rest, etc.
60 min. $150
90 min. $170

In-home Infant CST session 60min. $150

Partner Instruction for Prenatal Support at Home
90min. $170

Payment of Services
Payment is due at the time of service. Cash, check and credit cards accepted. A returned check will result in a $25 fee.

Arriving Late
In the event that you arrive late for your treatment, you will be given the remaining time allotted for your session. You will be charged the full price of your session. It is my hope that you will be on time for your session so that you may receive full benefit.

Cancellations
I require 24 hours notice of cancellations or appointment rescheduling. If 24 hours notice is not given, you will be charged the full fee of your treatment. This does not apply to expectant mother's in cases of medical emergency or labor but must be accompanied by a doctor's note to avoid being charged.

Please sign below stating that you understand and agree to adhere to the policies listed above.

Name _____   Date _____