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 ___________

Thank you for allowing me to support you during this amazing time of transition and anticipation. It is my intention to provide you a safe and nurturing experience during or after your pregnancy.

General Information

Massage therapy during pregnancy or postpartum is not intended to replace prenatal and postpartum care. Used as a form of adjunctive healthcare, potential benefits are:
✓Reduces stress and promotes relaxation and normal blood pressure
✓Relieves muscle spasms, cramps and myofascial pain, especially in the back,neck, hips and legs. ✓Increases blood and lymph circulation and supports the physiological processes of pregnancy ✓Reduces stress on weight-bearing joints and eases musculoskeletal strain and pain
✓Provides emotional support and physical nurturance
✓Enhances a woman's kinesthetic awareness and her ability to relax deeply which may be helpful during labor
✓Offers labor supportive techniques that may increase comfort during labor
✓Promotes shorter, less painful labors and reduction of complications, including prematurity and interventions
✓Assists postpartum restoration of abdomen and weight-bearing muscles and joints
✓Provides new mothers postpartum support with the physical and emotional aspects of infant care ✓Promotes healing, including post-cesarean scars

High Risk Pregnancies

Pregnancy massage is beneficial even if you are experiencing a high risk pregnancy.
The following are some conditions I need to be aware of in order to modify your treatment in the best interest of you and your baby. If you have any of the following conditions, please discuss your wish to receive prenatal massage with your healthcare provider and obtain his or her written consent, along with any applicable modification recommendations.

____

High Risk Factors (Please check all that apply)

_ Pre-pregnancy diabetes _ Genetic disorder/ DES exposure/ Uterine abnormalities
_ Cardiac disorders _ Hypertension/ high blood pressure _ Thyroid disorder
_ Multiple Pregnancy _ Asthma _ Rh negative _ Drug/ Alcohol use
_ Previous complications of pregnancy _ Renal/ liver/ blood/ convulsive disorders

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Pregnancy Complications (Please check all that apply)

_ Gestational Diabetes _ Fetal development complications _Anemia
_ Threatened miscarriage _ Early labor _ Placental dysfunctions
_ Cesarean birth (previous or planned) _ Pregnancy-induced hypertensive disorders (preeclampsia/ eclampsia/ toxemia)

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Non- Pregnancy Related Complications (Please check all that apply)

_ Cancer or undiagnosed lumps
_ Infection
_ Autoimmune disorder
_ Other:

Contraindicated for affected areas only:
_ Severe varicose veins
_ Thrombophlebitis
_ Skin irritations/ discharge
_ Fracture/ bleeding, burns, other acute injury

Release for Therapeutic Massage During Pregnancy

I verify that I have been informed of the possible benefits and contraindicated conditions for massage therapy during pregnancy. I will discuss with my physician/certified healthcare provider any health concerns that I have about massage therapy. I further verify that: (check one)

________ I have not had nor do I now have any prenatal complications nor any of the conditions listed on the previous page.

________ I have noted on the previous page all prenatal complications, risks, or conditions I am/ have experienced AND I have obtained
my maternity healthcare provider's release.

I understand that I will be receiving massage therapy and bodywork as a form of adjunctive health care only and that the massage therapy I receive is not a substitute for obstetric prenatal or perinatal care from a medical doctor or other licensed provider.

I hereby release and hold harmless and defend the practitioner from any claims, liability, demands and causes of action arising from my participation in this therapy.

Signature:____ Date:__________________________________
Print Name: ____

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Release with Care Provider Consent for Therapeutic Massage During Pregnancy

Dear Care Provider,
Your patient, ____, has requested prenatal therapeutic massage. Therapeutic massage during pregnancy is provided as adjunctive health care by a massage therapist who has been certified in Pre- and Perinatal Massage Therapy (certification requires completion of a comprehensive hands-on training program as well as passing both a written & practical exam).

It is my policy to work with prenatal clients who are experiencing or exhibiting potential contraindications and/ or whose pregnancy is considered high risk only with written express consent of the treating health care provider. I ask that you give your permission, stating any specific limitations or precautions that you feel appropriate for this client.

Please verify your clearance of this request by your signature below. This verification can be modified or withdrawn at any time should your patient's health status change. I welcome this opportunity to work with you providing prenatal care to your patient. Thank you for your time and assistance.

Patient's pregnancy is: ______ low risk ________ high risk
Specific limitations or precautions:

You may contact me directly for clarification or concerns regarding this patient. ______ yes ______ no
Signature:____ MD, DO, Midwife Date: ____________
Print Name:____
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