

Pregnancy/Prenatal Form

Name _____ Phone () ____ - ____ Date ____/____/____

How many weeks along: _____ Due Date () ____ - ____

Emergency Contact

Name: _____ Relationship _____ Phone () ____ - ____

OB/GYN or Midwife

Name: _____ Office Phone () ____ - ____ Emergency Phone () ____ - ____

Because some conditions during pregnancy are contraindicated for massage, please check all that apply to you:

- Vaginal Bleeding or Spotting
- Morning Sickness, Nausea, or Vomiting (Constant)
- Diarrhea (Extreme)
- Vaginal Discharge (Green, Yellow, Gray, Pink or Watery)
- Abdominal Pains
- Sudden Swelling or Edema (Extreme)
- Fever
- Excessive Protein in the Urine
- Rapid Weight Gain
- Blurring Vision
- Decreased Fetal Movement over a 24-Hour Period (After 20th Week)
- Placenta Previa - Palpation Can Cause Local Placental Separation and Precipitate Hemorrhage
- Toxemia

If any of the above are marked, please explain:

Any other conditions that we should be aware of:

Always consult your OB/GYN or Midwife before receiving a pregnancy massage.

Client Signature _____