Prenatal Intake and Health History Form - CONFIDENTIAL INFORMATION

1. What discomforts, pain, or other needs are you hoping to have addressed through this massage therapy?

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2. In what week of your pregnancy are you? ______________________________

3. Are you regularly seeing a physician, nurse-midwife, or midwife? ________________________

4. Have you had any complications or problems with this pregnancy? Check all that apply.

__ Bleeding
__ Protein in urine
__ Vomiting
__ Cramping
__ Rapid weight gain
__ Headaches
__ Water retention
__ Severe nausea
__ Abnormal fetal growth, heartbeat or movements
__ High blood pressure
__ High blood sugar
__ Other: ____

5. Do you have any medical conditions? Check all that apply.

__ Diabetes
__ Heart, liver, kidney or lung disorders
__ Convulsive disorders
__ Uterine abnormality
__ Connective tissue or collagen diseases
__ Other: ____

6. Are you currently experiencing any infection or disorder? Check all that apply.

__ Cold
__ Bladder infection
__ Varicose veins
__ Skin irritation
__ Other: ____

7. Is your pregnancy considered to be high risk? (Diabetes, hypertension, multiple pregnancy, previous complicated pregnancy, asthma, Rh or genetic problems, under 20 or over 35 years old, fetal genetic disorders, or exposure to hazardous materials)

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