



Pregnancy Massage Client History

Surname: _____	First names: _____
Address: _____	
Email: _____	Phone: _____
Occupation: _____	Date of Birth: _____
Emergency Contact: Name _____	Phone: _____
Due Date: _____	Prenatal Care provider: _____
Number of Previous Pregnancy's: _____	Children ages: _____
Children Names: _____	

Current Medication, Including Aspirin, Ibuprofen, Herbs, Vitamins, Etc: _____

Primary reason for appointment/Areas of Pain or Tension: _____

Have you experienced any of the following? Please circle

Heart/ Blood circulation disorders	Y / N	Low back pain	Y / N
Spinal Disorders	Y / N	Sciatica / Gluteal pain	Y / N
Illness	Y / N	Hip Pain	Y / N
Injuries	Y / N	Separation of Symphysis pubis	Y / N
Surgeries	Y / N	Separation of Abdominal muscles	Y / N
Osteoporosis / Arthritis	Y / N	Leg Cramps	Y / N
Varicose Veins	Y / N	Carpal tunnel	Y / N
Allergies / Skin Problems	Y / N	Nausea	Y / N
Headaches	Y / N	High Blood Pressure	Y / N
Pain / Numbness	Y / N	Oedema / Swelling	Y / N
Bladder infection	Y / N	Diabetes	Y / N
Uterine bleeding	Y / N	Preterm Labour	Y / N
Chronic Hypertension	Y / N	Abdominal Cramping	Y / N
Blood clot or Thrombophlebitis	Y / N	Preeclampsia	Y / N
Placenta insufficiency	Y / N	More than 2 consecutive miscarriages	Y / N
Severe itching (palms or feet)	Y / N	Other please specify:	

Please specify if you answered yes to any of the above questions: _____

Have you or a family member previously experienced a high-risk pregnancy? _____

Do you consent to massage of the abdomen? _____

I _____ certify that the information I have given is correct to the best of my knowledge and I will keep my therapist updated with any medical changes.

Signed _____

Date _____