Client History Form for Pregnant Moms

Referred By: _____

Please print, complete, and bring this form with you to your scheduled massage appointment. This information is not for diagnosis, but intended so that the therapist may provide you with an effective *and holistic* massage therapy treatment from the perspective that mind, body and spirit are connected and influence our health and wellness. Your therapist will discuss this form with you at the beginning of your appointment. Everyone's time is valuable. Please notify the therapist if you are on a time constraint. To avoid cancellation fees, kindly give 24 hours notice for appointments that need to be re-scheduled. ***All information is confidential.***

Name_____ Date_____

Address _____ Phone # _____

E-mail _____ Your Birth Date: _____

Occupation _____

Does it involve long periods of (please circle all that apply):

Sitting Standing Computer terminal work Telephones

Other: _____

Expected Due Date: _____

Number of Pregnancies: _____ Number of Births: _____

Pre-natal Care Provider: _____

When do you plan to begin maternity leave? _____

Have you ever experienced therapeutic massage before? _____

Have you ever experienced pregnancy massage before? _____

List all current and past health problems:_____

_____

List all medications you are currently taking include non-prescription meds, supplements, herbs:

_____

List any allergies to meds and reaction:_____

List all of your lifetime surgeries and major injuries: _____

_____

Are you currently under a Physician's care? _____ If so, for what reason? _____

Name: _____ Phone #: _____ How long? _____

Are you currently under an Acupuncturist's care? _____ If so, for what reason? _____

Name: _____ Phone #: _____ How long? _____

Are you currently under a Chiropractor's care? _____ If so, for what reason? _____

Name: _____ Phone #: _____ How long? _____

Are you currently under a Nutritionist's care? _____ If so, for what reason? _____

Name: _____ Phone #: _____ How long? _____

Are you taking a Childbirth Education Class? _____ If so, with whom? _____

Please describe your normal diet: _____

Are you supplementing your diet with any vitamins, herbs, shakes or nutritional supplements? _____

If so, what kind? _____

Please describe your exercise habits: _____

Please describe your sleeping habits: _____

Any past emotional trauma? Yes No Explain: _____

_____

Circle Any of the Following That May Apply to You:

Can't make decisions	Feel panicky	Unable to relax
Always tired	Trouble breathing	Fainting spells
Nightmares	Recurrent dreams	Insomnia
No appetite	Stomach trouble	Over-eating
Home conditions bad	Job problems	Financial difficulties

Do you have any history of, or are you currently experiencing: (Please circle any that apply)

High blood pressure	Low blood pressure	Pre-term labor
Thyroid problems	Gestational Diabetes	Headaches
Sinus congestion	Diarrhea	Varicose Veins
Carpal Tunnel	Heavy bleeding	Breast tenderness
Upper back pain	Problems breathing	Edema

REVIEW OF SYSTEMS

Please describe any problems you are having with any of these body systems or areas. There are some conditions that are contraindicated for massage and therefore, your appointment may need to be re-scheduled. Your massage therapist will discuss these with you.

HEAD (ear, nose, throat, etc.):

_____

GLANDULAR (any lumps or pain in glands):

_____

CARDIOVASCULAR (heart, lungs, circulation):

_____

REPRODUCTIVE SYSTEMS (pregnancies, surgeries):

_____

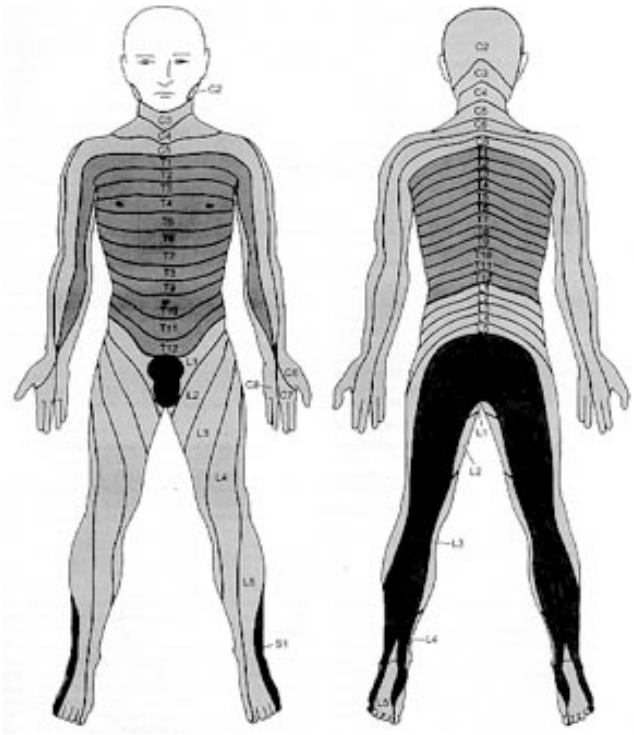
DIGESTIVE SYSTEMS (stomach problems, ulcers, constipation, IBS, severe cramping):

_____

MUSCULOSKELETAL (torn muscles, ligaments, spasms, herniated discs, vertebral subluxations)

_____

Please mark where you have pain or body tension and categorize each mark as being an ache, a shooting pain, a burning sensation sore muscle.



Signed: _____ Date: _____

Back Creek Massage & Bodywork, LLC 7646 Mt. Chestnut Rd. Roanoke, VA 24018
540.761.8022 Lindsay@BackCreekMassage.com www.BackCreekMassage.com