Pregnant Client Intake

## Personal Information

Name: ______________________________ Home Phone #: ________________________________

Birthdate: ______________________________ Cell Phone #: ________________________________

Address: ______________________________ Email Address: ________________________________

______________________________

☐ by checking here I agree to receive appointment reminders via text or email

Occupation: ______________________________________________________________

Hobbies/activities/recreational pursuits: ______________________________________________________

______________________________________________________________________

Therapist use only:

## Emergency Contact

Name: ______________________________ Relationship: ______________________________

Phone #: ______________________________

## Massage Experience

Have you received a professional massage before? ☐ yes ☐ no

If yes, what type or types? ______________________________________________________

What do you like about massage? ______________________________________________________

What do you dislike about massage? ______________________________________________________

Pressure Preference? ☐ light ☐ moderate ☐ deep ☐ not sure

Therapist use only:

## Medical History

Primary care physician: __________________________________ Date of last visit: _________________

Other relevant health care professionals: ______________________________________________________

Medications (prescribed/over the counter): ______________________________________________________

______________________________________________________________________

Supplements/herbs: ______________________________________________________

Allergies: ____________________________________________________________

Tobacco use: How many packs per day? ______ How many years? ______ If quit, when? _________

Therapist use only:

Have you had any (if yes, please explain)

- ☐ Hospitalizations: ______________________________________________
- ☐ Accidents or injuries: __________________________________________
- ☐ Surgeries: ___________________________________________________

Therapist use only:

Check all that apply:

**Musculoskeletal**
- ☐ Tendonitis/bursitis
- ☐ Arthritis
- ☐ Sprain/strain
- ☐ Fracture
- ☐ Dislocation
- ☐ Spinal disorder
- ☐ Headache/migraine
- ☐ Spasm/cramp
- ☐ TMJ
- ☐ Osteoporosis

**Circulatory**
- ☐ Heart condition
- ☐ Stroke/TIA
- ☐ Aneurysm
- ☐ Phlebitis/varicose veins
- ☐ Blood clot
- ☐ High/low blood pressure
- ☐ Lymphedema

**Respiratory**
- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Sinus problem

**Nervous**
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Paralysis
- ☐ Shingles
- ☐ Numbness/tingling
- ☐ Chronic pain
- ☐ Fatigue
- ☐ Sleep disorder
- ☐ Seizure disorder
- ☐ PTSD/traumatic brain injury

**Digestive**
- ☐ Crohn's disease/colitis
- ☐ IBS
- ☐ GERD/reflux
- ☐ Bladder/kidney ailment

**Skin**
- ☐ Rash
- ☐ Rosacea/acne
- ☐ Burn
- ☐ Fungal infection
- ☐ Herpes/cold sore
- ☐ Wart

**Reproductive**
- ☐ Pregnant
- ☐ Endometriosis/Fibroids
- ☐ Ovarian/menstrual problems
- ☐ Prostate problem

**Other**
- ☐ Hepatitis A/B/C
- ☐ Fibromyalgia
- ☐ Cancer/tumor
- ☐ Diabetes
- ☐ Depression
- ☐ Anxiety
- ☐ Chemical dependency
- ☐ Autoimmune disease
- ☐ Piercing/tattoo
- ☐ Contact lenses
- ☐ Dentures
- ☐ Hearing aids
- ☐ __________________________
- ☐ __________________________

Therapist use only:

**Pregnancy**

How far along are you? _________

Is this your first pregnancy? ☐ yes ☐ no

Prior c-section? ☐ yes ☐ no

Any previous or current complications? ☐ yes ☐ no

| Therapist use only: |
| --- |
| |

Many women experience sensitivity in their breasts, particularly in connection with pregnancy. Careful and respectful massage of the breasts can assist with the elimination of congestion in the breast tissue through increased circulation. This can often assist in reducing breast sensitivity and can improve the health of the breast tissue.

Consent for breast massage: ☐ yes ☐ no

**Client agreement:**

By signing below, you agree to the following:

- I acknowledge that physical/massage therapy is not a substitute for medical care, examination, and diagnosis.
- Information exchanged during a therapy session is educational in nature and is intended to help me become more familiar with my own health status and is to be used at my own discretion.
- I understand that there is no implied or stated guarantee of the effectiveness of physical/massage therapy.
- The information that I provided is accurate and complete to the best of my knowledge and I agree to inform my therapist if any of the above information changes at any time.
- Regarding minors (those under 18 years old): I give permission to treat the minor that I am responsible for and understand that I must accompany the minor during the session.
- I understand that the therapist reserves the right to refuse service or terminate a session based upon the client's condition, therapist's skill set, client attitude or client actions.
- I am aware of the risks and benefits of physical/massage therapy and give my consent for treatment.

Client signature: ______________________________________________ Date: _______________

Parent/legal guardian name: _____________________________________
(if client is under 18 years old) print

Parent/legal guardian signature: __________________________________ Date: ________________
(if client is under 18 years old) sign

Therapist signature: ____________________________________________ Date: ________________
Brian D. Anderson, PT, OCS, LMT

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