



Pre Natal Massage Intake Form

Welcome and Congratulations! We want to take the very best care of you and your baby, so relax and enjoy your treatment with our fully capable NYS Licensed Therapist.

Name: _____ Date: _____

Address: _____

E-mail: _____

Phone: _____ Date of Birth: _____

OBGYN Doctor: _____ Phone: _____

Emergency Contact Information:

Name: _____ Relation: _____

Phone: _____

How many weeks/ months into the pregnancy are you? _____

With this pregnancy or any other, have you had any of the following?

- | | | | |
|---------------|--------------|-------------|------------|
| ➤ Placenta | ➤ Contagious | ➤ Varicose | ➤ Extreme |
| ➤ Previa | ➤ skin rash | ➤ Veins | ➤ swelling |
| ➤ Spotting | ➤ Recent | ➤ Seizures | ➤ Blood |
| ➤ Braxton | ➤ accident | ➤ Migraine | ➤ clotting |
| ➤ Hicks | ➤ PreClampia | ➤ headaches | ➤ Cold/Flu |
| ➤ Gestational | ➤ Cramping | ➤ Melanoma/ | ➤ Bruise |
| ➤ Diabetes | ➤ High Blood | ➤ hyperpigm | ➤ Easily |
| ➤ Allergies | ➤ Pressure | ➤ entation | ➤ Aneurysm |
| ➤ Sciatica | | | |

Does your Doctor consider you high risk? _____ If yes, why? _____

Have you had any miscarriage(s)? _____ If yes, when? _____

Signature: _____ Date: _____