CONFIDENTIAL CLIENT INFORMATION & HEALTH HISTORY w/ Pregnancy Questionnaire

First Name: _____ M.I._____ Last Name:_____

Address: _____ City:_____State: _____ Zip: _____

Phone (H):_____ (C)_____Date of Birth: _____

Occupation:_____ Emergency contact: _____

Phone: _____ Relationship: _____

Referred by _____e-mail:_____ Add me to your newsletter: Yes No

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Delivery Due Date: _____Weeks Pregnant_____

Name of Obstetrician/Midwife _____ Phone: _____

Please describe how you have felt (physically and emotionally) during this pregnancy: _____

_____

_____

Have you had any complications or abnormalities? _____ If yes, please describe: _____

_____

If yes, do you have the approval of your midwife or physician to receive massage? _____

Are you currently doing any prenatal exercise or yoga?_____

Are you experiencing any tension or soreness in your muscles at this time? _____

If yes, please describe: _____

Are you sensitive to any scents or smells? _____

Would you like to have your abdomen massaged? o yes o no

Is there anything else you would like to discuss about your pregnancy? _____

Is this your first professional massage? _____ If no, how frequently do you get a massage? _____

What do you hope to accomplish from today's massage? _____

Are you aware of any tension holding spots in your body? _____ If yes, location(s) _____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago:_____

More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

Do you feel that you have recovered from these events? _____ Please explain: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? _____

Please explain: _____

Describe what activities cause this pain and/or make it worse: _____

Are you receiving any other type of medical treatment? _____ Please explain: _____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

_____

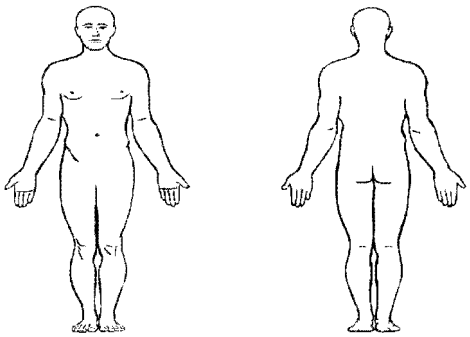
Are you currently under the care of a physician? _____ Whom?_____

Please list reason(s): _____

Are there any other health concerns you wish to discuss today? _____ If yes, please describe: _____

_____

Please indicate where you experience pain on the drawing below



Are you currently experiencing any of the following conditions?

_____ Flu or Cold _____ Inflammation _____ Fever _____ Infection _____ Contagious Disease

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

MUSCULOSKELETAL
___ Fibromyalgia
___ Spasms/Cramps
___ Sprains/Strains
___ Osteoporosis
___ Postural Deviations
___ Gout
___ Osteoarthritis/Rheumatoid Arthritis
___ TMJ Disorders
___ Cysts
___ Bursitis
___ Bunions
___ Shin Splints
___ Plantar Fasciitis
___ Tendonitis
___ Torticollis
___ Whiplash Syndrome
___ Carpal Tunnel Syndrome
___ Sciatica
___ Thoracic Outlet Syndrome
___ Headache
___ Leg Pain
___ Arm Pain/Shoulder Pain
___ Low Back Pain
___ Mid Back Pain
___ Hip Pain
___ Other _____

NERVOUS SYSTEM
___ ALS
___ Encephalitis
___ Meningitis
___ Sleep Disorders
___ Multiple Sclerosis
___ Parkinson's disease
___ Bell's palsy
___ Neuritis
___ Spinal Cord Injury
___ Stroke
___ Trigeminal Neuralgia
___ Seizure Disorders
___ Numbness/Tingling/Twitching
___ Other _____

CIRCULATORY
___ Anemia
___ Leukemia
___ Aneurysm
___ Atherosclerosis
___ Deep Vein Thrombosis
___ Hemophilia
___ Hypertension
___ Low Blood Pressure
___ Reynaud's Disease
___ Varicose Veins
___ Heart Condition
___ Blood Clots/Phlebitis
___ Diabetes
___ Other _____

DIGESTIVE
___ Ulcers
___ Irritable Bowel Syndrome
___ Colitis
___ Gallstones
___ Hepatitis
___ Crohns Disease
___ Diarrhea
___ Gas/Bloating
___ Indigestion
___ Other _____

RESPIRATORY
___ Pneumonia
___ Sinusitis
___ Asthma
___ Trouble Breathing
___ Dizziness
___ Other_____

SKIN
___ Fungal Infections
___ Athletes Foot
___ Cellulitis
___ Impetigo
___ Herpes simplex
___ Open Wound or Sore
___ Rashes/Hives
___ Warts/Moles
___ Dermatitis/Eczema
___ Acne
___ Psoriasis
___ Skin Cancer
___ Precancerous Lesions
___ Skin Injuries
___ Other _____

OTHER
___ Insomnia
___ Anxiety/Panic Attacks
___ PMS
___ Grief Process
___ Cancer
___ Substance Abuse
___ Pregnancy
___ Chronic Fatigue
___ HIV/AIDS
___ Lupus
___Tinnitus
___Vertigo
___ Bladder Infection
___ Postoperative Situation
___ Other _____

Do you have any of the following prenatal conditions or symptoms?

- o Multiple Gestation
- o Preterm Labor
- o Decreased Fetal Movement in past 24 hours
- o Excessive Swelling of Hands, Legs / Face
- o Vaginal Bleeding /Abnormal Discharge
- o Gestational Diabetes
- o Abdominal Pain (or unusual pain else where in your body)
- o Toxemia/Preeclampsia
- o Nausea/Vomiting

(The above conditions are contraindicated for massage – If you marked any of them your therapist may need the approval of your physician to continue or may not be able to work on you at this time.)

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature: _____ Date: _____