Stacy Bullock, Certified Nurturing the Mother ® Massage Therapist

Health History Form for Postpartum Massage

Name: ____ Date: __________

Address: ____

City: ________________________ State: _________ Zip Code: ____________

Home Phone: __________________ Work Phone: ________________________

Cell Phone: ____________________ E-mail: ____________________________

Date of Birth: ___________________ Height: _____________ Weight: _________

Date of First Massage Appointment: ______________________________________

Delivery Date: ___________________

Number of Births: _______________

Physician/Health Care Provider: ____

Please circle all answers that apply.

Have you ever experienced a therapeutic massage before?	Yes	No
Did you receive a pregnancy massage before?	Yes	No
Are you currently taking any medications?	Yes	No

If YES, what are they? ____

____

Do you currently have any areas of discomfort?	Yes	No

If YES, what are they? ____

____

List any previous injuries or surgeries here: ________________________________

____

How did you find me? Who referred you to me? ____________________________

When do you plan to return to your former occupation? ______________________

Did you experience any complications with your delivery?	Yes	No

If YES, please explain: ____

____

____

Please circle all answers that apply. Do you have any history of, are you currently experiencing:

High Blood Pressure	Low Blood Pressure	Pre-term Labor
Thyroid Problems	Edema/Swelling	Headaches
Morning Sickness/Nausea	Sinus Congestion	Heartburn
Constipation	Hemorrhoids	Diarrhea
Varicose Veins		

Other medical conditions not listed: ______________________________________

____

How much water do you drink each day? ____________________________________

Are you doing any form of exercise, such as yoga, walking or swimming? ___________

____

Other stress reducing activities or hobbies? _______________________________

____

Finally, Favorite Restaurant or Store*: ____________________________________

***I like to reward returning clients with the occasional gift card.**

Legal Disclaimer: I understand if I experience any pain or discomfort during my session(s), I will immediately inform the therapist so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork is not to be used as substitute for medical examination, diagnosis, or treatment by a physician. I acknowledge that if I have any mental or physical condition, I should see the appropriate qualified health care professional (physician, psychologist, etc.) Because massage should not be done under certain medical conditions, I affirm I have stated all my known medical conditions and answered all questions truthfully. I agree to keep the therapist updated as to changes in my medical conditions, and understand that there shall be no liability on the therapist's part should I forget to do so.

Client Name: ____

Client Signature: ____