Stacy Bullock, Certified Nurturing the Mother ® Massage Therapist

Health History Form for Pregnancy Massage

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Date of Birth: _____ Height: _____ Weight: _____

Number of Births: _____ No. of Pregnancies: _____

Expected Due Date: _____ How many weeks are you now? _____

Physician/Health Care Provider: _____

Please circle all answers that apply.

Have you ever experienced a therapeutic massage before? Yes No

Have you ever experienced 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? _____

What is your current occupation? _____

Does it involve long periods of:

Sitting Standing Computer Work Telephone Work

Other: _____

When do you plan to begin maternity leave? _____

Please circle all answers that apply. Do you have any history of:

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? _____

How often do you exercise/stretch? _____

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: _____