SHIFRA
CENTRE FOR WELLNESS

Prenatal Massage Health History

Name: _____ Birth Date: _____
Address: _____ Postal Code: _____
Home Phone: _____ Bus. Phone: _____
Occupation: _____ E-Mail (for massage discounts): _____
In Emergencies, Notify: _____ Phone: _____
Referred by: _____
Recreational Activities: _____

Health Care Provider

Medical Doctor: _____ Chiropractor: _____ Naturopath: _____
OB: _____ Midwife: _____ Doula: _____
Other Health Care: _____
Do you attend regular visits with your caregiver? *Y* *N*
When was your last appointment? _____
Has treatment been approved by your medical doctor? *Y* *N*

Health Questionnaire

Previous Injuries/Surgeries: _____
History of Cancer: *Y* *N* Type: _____

Have you ever had a prenatal massage before? *Y* *N*
Is this your first pregnancy? *Y* *N*
Are you experiencing any nausea? *Y* *N*
Are you presently taking any medications/ herbs/supplements?
Please list: _____
In what week of pregnancy are you? _____
When is your due date? _____
What discomforts, pain, or other needs are you hoping to have addressed through massage therapy?
_____
_____

Please check any complications or problems you have had with this pregnancy:

( ) Bleeding
( ) Cramping
( ) Amniotic Fluid Leakage
( ) Water Retention
( ) High Blood Pressure
( ) Rapid Weight Gain
( ) High Blood Sugar
( ) Protein in the Urine
( ) Visual Disturbances
( ) Severe Nausea
( ) Vomiting or Headaches
( ) Abnormal Fetal Growth/ Heartbeat/ Movement

Other: _____

Please check any applicable medical conditions:

( ) Diabetes
( ) Heart Disease
( ) Liver Disease
( ) Kidney Disease
( ) Lung Disease
( ) Uterine Abnormality
( ) Convulsive Disorders
( ) Connective Tissue or Collagen Disease

Other: _____

Please check any infection or disorder that you may currently be experiencing:

( ) Cold/ Flu
( ) Bladder Infection
( ) Skin Irritation
( ) Varicose Veins

Other: _____

High Risk Pregnancies

Please check the following that may apply:

( ) Pre-pregnancy Diabetes Mellitus
( ) Cardiac/ Pulmonary/ Renal or Liver Disease
( ) Chronic Hypertension
( ) Previous Problem Pregnancies
( ) Multiple Pregnancies
( ) Age < 20 or > 35
( ) Drug or Hazardous Material Exposure
( ) Rh- Mother or Genetic Problems
( ) Asthma
( ) Convulsive Disorders

Is there anything else relevant about this pregnancy or about you that I should know?

_____
_____
_____

I hereby verify that I have stated all known medical conditions pertaining to my pregnancy, and the health history is accurate, complete, and current. I agree to advise the therapist of any changes or conditions that may arise which could be inadvisable for me to receive massage. I do forever release the massage therapist from any and all liability that may arise directly or indirectly out of my participation in massage therapy. All of the above information is strictly confidential and will not be disclosed without written consent of the client.

Cancellation policy: 24 hours notice is required for cancellation of appointments. As well, please be aware that in order to provide timely service to all of our clients, late arrival to an appointment will result in shorter treatment duration.

Client Name: (Please print) _____ Date: _____

Client Signature: _____