Inner Peace Massage
world peace...one massage at a time
145 South 56th St.
Suite A
Lincoln, NE 68510

Pre-Natal Intake Form

Name: _____ Telephone: (Home) _____

Address: _____ (Cell) _____

City, State, Zip: _____ Birth Date: _____

Your Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Email: _____Referred by: _____

How did you hear about us? Internet Friend Google Other_____

First Professional Massage? : (circle) Yes No If No how frequently do you have massage:

_____

Are you presently under physician or chiropractic care? Yes No

Are you currently taking a prescribed medication? Yes No

If yes, please list the name of medication and condition for which medication is prescribed:

_____

_____

List any accidents/injuries/surgeries: when they occurred and treatment received and if any lingering effects please explain:

_____

_____

_____

_____

Have you been hospitalized in the last 4 months? Yes No

Please list any allergies you may have: _____

Prenatal Care Provider/ Doctor_____ Phone:_____

May I have permission to contact your care Provider? Y N

My due date is _____

This is my _____ (number 1st, 2nd ,etc.) pregnancy. This will be my _____(number 1st, 2nd …) birth

I am _____ (number) weeks pregnant in my ___ (1st, 2nd, 3rd) Trimester

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Client History (helps determine treatment options):

Please check (v) current problems, Mark with (+) if you had in the past:

__Anemia
__Leaking amniotic fluid*
__Bladder infection*
__Uterine bleeding *
__Blood clot or phlebitis *
__Chronic hypertension*
__Abdominal cramping
__Diabetes (Gestational or mellitus)
__Edema/swelling
__Fatigue
__Headaches
__Insomnia
__High blood pressure*
__Leg cramps
__Miscarriage *
__Nausea
__Problems with placenta
__Pre-term Labor *
__Preeclampsia (toxemia) *
__Sciatica
__Separation of the rectus muscles
__Separation of the symphysis pubis
__skin disorders/athletes foot
__Twins or More*
__varicose veins
__visual disturbances*
__previous cesarean birth
__contagious conditions
__muscle sprain/strain
__heart attack/ stroke
__arthritis
__carpal tunnel syndrome
__allergy to nut oils
__low blood pressure
__bursitis
__hypo or hyperglycemia
__contact Lens

Other conditions or problems in current or past pregnancy

_____

_____

Anything else you would like me to know?

_____

_____

I am experiencing a Low Risk or High Risk (circle One)

Consent for Therapy:
I as a client agree to provide complete and accurate health information and notice of health changes. The above information is accurate. I understand that the massage is NOT sexually oriented in any way and that any illicit or suggestive remarks or behavior will result in immediate termination of the session. I understand that Massage Therapists do not diagnose disease or prescribe drugs and they are not a substitute for medical care. I understand that by signing this form, I give my consent to receive the treatment discussed. I have read this form and hereby freely give my permission to be massaged. I understand that a missed appointment might incur charges that I must pay.

Client Signature: Date: