THE WELLNESS STUDIO
FAMILY CHIROPRACTIC & WELLNESS CARE

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: ____
Email Reminders: Y / N

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?

____
____
____

Consent to Massage Therapy

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.

If desired, CUPPING THERAPY can provided during your treatment with the Cupping Practitioner, Heather Mix, and it has been explained to me that there is the possibility of local discolouration following this therapy that includes clearing of stagnation and toxins from the body. I understand that these marks last from a few hours to a week following treatment. I understand that aggressive exfoliation and extreme exercise or temperature change can produce undesirable after effects following cupping.

I, ______________________________ agree to allow the Cupping Practitioner, Heather Mix, to perform cupping on me and I have read and understood all of the information stated above.

Cancellation policy: 24 hours notice is required for cancellation of appointments otherwise you will be charged the full cost of the treatment. 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: ____

Witness Signature: ____