Prenatal Massage Client Information

Name: ______________________________ Date: ____________________

Occupation: ______________________________ DOB: ____________________

Have you ever received a professional massage? Yes No

Due Date: ______________________________

Primary reason for receiving a massage today: (ex: relaxation, back pain, stress relief, gift certificate)

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Prenatal Care Provider/Doctor:

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May we have permission to contact your care provider if necessary? Yes No

Contact Information:

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Do you have any specific areas of discomfort that you would like for your massage therapist to focus on?

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Please circle any of the following conditions or symptoms which apply to you:
(please specify what type, if applicable)

Morning sickness	Skin Sensitivities	Poor circulation
Excessive swelling	Headaches	leg cramps
Fevers	Vaginal Bleeding/Abnormal Discharge	sciatic pain
High/Low Blood Pressure	diarrhea	TMJ
Gestational Diabetes	carpal tunnel syndrome	Past Pre-term Labor