Tempo Therapeutic Massage, LLC
Tracy S. Kaufman, MSW, LMT, NCTMB
Licensed Massage Therapist

CONFIDENTIAL PREGNANCY MASSAGE INTAKE FORM

Name _____ Date of Birth _____

Delivery Due Date _____ Week of Pregnancy _____
Number of pregnancies (including this one) _____ Number of births _____
Number of cesarean births _____
Prenatal Care Provider _____ Phone Number _____

May I have permission to contact your care provider with any concerns related to massage during your pregnancy? _____ Yes _____ No

Is this your first pregnancy massage? _____ Yes _____ No

What areas of discomfort, pain, tension, or other needs would you like to have addressed in your massage session?

_____

_____

_____

Would you like to have your abdomen massaged? (Light stroking and rocking during the 2nd and 3rd trimester as long as there are no other contraindications – facilitates relaxation, reduces skin dryness and itchiness, reduces leg edema, enhances connection with baby)

_____ Yes _____ No

Are there any body areas you prefer NOT to be massaged during your pregnancy? (Mark all that apply)

_____ Face _____ Head _____ Neck _____ Hands _____ Chest
_____ Abdomen _____ Arms _____ Forearms _____ Hips _____ Feet
_____ Other (Please define) _____

IMPORTANT:
The health and safety of you and your baby are very important to me. The following lists provide risk factors, complications, and conditions that may be affecting you during your pregnancy. This information will help me make sure your massage session is safe and enjoyable for both you and your baby. You should discuss any of these conditions or concerns with your Prenatal Care Provider prior to receiving a massage. Please notify your massage therapist any time you experience a new condition or a change in a current condition.
Please check (√) any of the following high risk factors, complications, or conditions that you are experiencing during this pregnancy. Mark with a plus (+) if you have experienced a complication or condition in the past.

High Risk Factors:

____ Mother's age under 20 or over 35	____ Pulmonary (lung) disorder or asthma	____ Previous complications of pregnancy
____ Multiples (twins, triplets…)	____ Renal (kidney) disorder	____ Thyroid disorder
____ Previous premature birth	____ Cardiac (heart) disorder	____ Genetic disorder / DES exposure
____ History of repeat miscarriage	____ Hypertension / high blood pressure	____ Tobacco / Drug / Alcohol use
____ Pre-pregnancy diabetes	____ Convulsive disorder	____ Liver or blood disorder
____ Rh Negative	____ Uterine abnormalities	____ Obesity

Other Pregnancy Complications and Conditions:

Please mark complications/conditions that you are currently having with a check (√). If it is a complication/condition you have had during past pregnancies, please mark with a plus (+).

____ Gestational diabetes	____ Blood clots / Thrombophlebitis	____ Sciatica
____ Pre-term labor	____ Varicose veins	____ Leg cramps
____ Threatened miscarriage	____ Vision changes	____ Headaches
____ Cesarean birth (previous or planned)	____ Kidney, liver, and/or bladder disorders	____ Congestion / sinus pain
		____ Heartburn / Indigestion
____ Placental dysfunctions	____ Anemia	____ Constipation / Hemorrhoids
____ Uterine bleeding	____ Fetal development complications	____ Carpal tunnel syndrome
____ Abdominal cramping	____ Morning sickness / nausea	____ Fatigue
____ Swelling/Edema	____ Difficulty sleeping	____ Anxiety / Depression

____ Pregnancy-induced hypertensive disorders: (pre-eclampsia / eclampsia / toxemia)

____ Other: _____

Is there anything else you would like me to know about your health and/or pregnancy?

_____

_____

_____

I understand that massage therapy during pregnancy can be very beneficial in promoting relaxation, minimizing stress, reducing pain caused by muscle tension and musculoskeletal strain, improving circulation, and providing a positive and nurturing touch. I have received information about the benefits, precautions, and contraindications of massage during pregnancy. I have discussed any concerns with my Prenatal Care Provider and have obtained a signed release for massage therapy. The above information is accurate and true to the best of my knowledge. I have indicated any risk factors, complications, and or conditions that I am currently experiencing and will inform my therapist if there are any changes in my health at each appointment. I agree to immediately inform my therapist if I am experiencing any pain or discomfort during my massage so pressure and strokes may be adjusted to my level of comfort and safety. I understand that the massage therapist does not diagnose, prescribe, or treat any specific conditions. I understand that massage therapy is not a substitute for medical examination, diagnosis, and treatment and that it is recommended that I continue to see my prenatal care provider for any ailment or concerns I might have. I consent to receive massage therapy from Tracy S. Kaufman, Licensed Massage Therapist and Managing Member of Tempo Therapeutic Massage, LLC at my own risk and do hereby agree to hold harmless and indemnify the therapist from all claims, liabilities, damages, and actions that have arisen, or may arise directly from the therapy I and my child receive.

Signature _____ Date _____

Printed Name _____