



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) _____ | | | | |

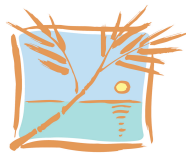
IMPORTANT:

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 (+).

- | | | |
|--|--|---|
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Blood clots / Thrombophlebitis | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Pre-term labor | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Threatened miscarriage | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Cesarean birth (previous or planned) | <input type="checkbox"/> Kidney, liver, and/or bladder disorders | <input type="checkbox"/> Congestion / sinus pain |
| <input type="checkbox"/> Placental dysfunctions | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heartburn / Indigestion |
| <input type="checkbox"/> Uterine bleeding | <input type="checkbox"/> Fetal development complications | <input type="checkbox"/> Constipation / Hemorrhoids |
| <input type="checkbox"/> Abdominal cramping | <input type="checkbox"/> Morning sickness / nausea | <input type="checkbox"/> Carpal tunnel syndrome |
| <input type="checkbox"/> Swelling/Edema | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Pregnancy-induced hypertensive disorders: (pre-eclampsia / eclampsia / toxemia) | | <input type="checkbox"/> Anxiety / Depression |
| <input type="checkbox"/> 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 _____