MASSAGE ITHACA

PRENATAL CLIENT INTAKE FORM

Name_____ Date of Birth _____ Sex _____

Address _____ City, State _____ Zip _____

Phone _____ Email _____

Emergency contact _____ Phone _____

**Please answer the questions below.

How did you hear about me? _____

Have you received massage therapy or bodywork before? ☐ Yes ☐ No

Date of last Massage: _____ Therapist Seen: _____

Chiropractor? _____ Physical Therapist?_____

Acupuncturist? _____ Areas to avoid? _____

Midwife/OGYN? _____ Birth plan? ☐ Yes ☐ No Home or Hospital?

Medications, Vitamins, or herbs? ☐ Yes ☐ No If yes, which ones_____

**Please mark any of the following conditions you may currently have.

☐ Recent injury	☐ Bruise easily	☐ Recent surgery
☐ Infection	☐ Old Injuries	☐ Arthritis/tendonitis
☐ Skin condition	☐ Fibromyalgia	☐ Circulation issues
☐ Head, neck, ear pain	☐ Blood clots	☐ Chronic/acute pains
☐ Whiplash	☐ High/low blood pressure	☐ High risk birth
☐ Headaches	☐ Varicose veins	☐ (Gestational) Diabetes
☐ Allergies to products	☐ Heart condition	☐ Numbness/tingling
☐ TMJd	☐ (Pre)Eclampsia	☐ Other, please specify:

_____

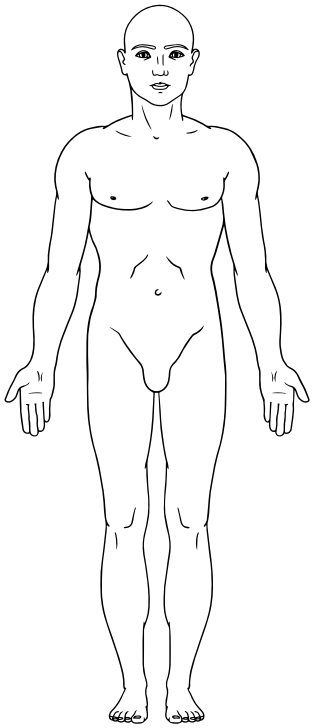
**Do you have any acute (within the last 3 days) injuries or illnesses? ☐ Yes ☐ No

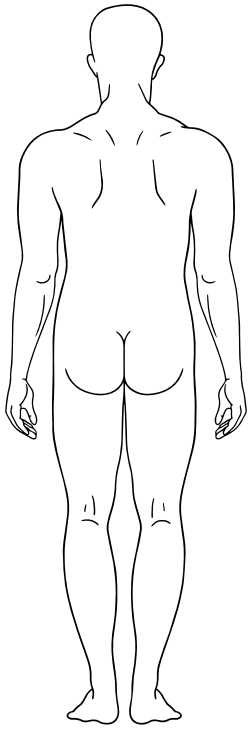
---

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose diseases, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination; rather, it is a form of health and wellness utilizing various techniques and modalities. I take responsibility for alerting my therapist to any physical, mental or emotional changes that could affect this work.

Signature _____ Date _____

On the body diagram below, please shade, X, or circle the areas of feeling pain or tension in your body right now:





Circle the number below to indicate your present level of PAIN:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable) **Is the pain always present?** YES / NO

What makes it feel BETTER? _____

What makes it feel WORSE? _____

What is your occupation? _____

Circle your job requirements: **Heavy Labor** **Light Labor** **Mainly Sitting** **Mainly Standing**

Can you perform your daily activities? **Yes, all activities.** **Only some.** **Not at all.**

How many weeks / when is your due date: _____

--------DO NOT FILL BELOW THIS LINE --------Therapist Notes:

Stress reduction techniques:

Recommendations:

Recommended for next appointment: