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New Patient Information Packet – Pregnancy

Date: _____

Name: _____ Sex: □ Male □ Female
First M.I Last
Pronouns: _____

Nickname/Preferred Name: _____ DOB: _____ Age: _____
D / M / Y

Address: _____
Street City State Zip

Email: _____ Phone:_____ □ Work □ Cell □ Home

Appointment Reminders: □ Text □ Email May we leave messages at this number? □ Yes □ No

Emergency Contact:_____ Pronouns: _____
First M.I Last

Relation to Patient:_____ Phone:_____

Prenatal Care Provider/Doctor: _____
First M.I Last

Office: _____ Phone:_____

Do we have permission to contact your PCP if necessary? □ Yes □ No

How did you hear about us?

□ Social Media □ Google Search □ Referral/Word of Mouth □ Flyer

If you heard about us through word of mouth, who can we thank? _____

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Prenatal Massage Therapy Benefits

Prenatal Massage Therapy Benefits - There are several observed or identified potential benefits to massage therapy during pregnancy, including:

- Relieves muscular tension, especially in the lower back, upper back, shoulders and neck
- Reduces stress on weight-bearing joints
- Enhances body awareness for better posture and less discomfort
- Assists with body mechanics and movement during structural change
- Supports birth process by relaxing muscles involved in labor and birth
- Eases anxiety and stress during time of transition
- Provides emotional support and nurturance

Prenatal Massage Therapy Contraindications - Performing massage therapy during pregnancy is contraindicated for women experiencing any of the following symptoms/signs:

- Bloody discharge
- Continual abdominal pains
- Sudden, rapid weight gain
- Severe headaches
- Excessive hunger and thirst
- Visual disturbances
- Fever
- Diarrhea
- Excessive swelling in arms or legs
- Decrease in fetal movement over a 24-hour period
- Increased urination in the second trimester
- Increased blood pressure
- Severe back pain that does not subside with change in position
- Severe nausea and/or vomiting (cannot keep anything down)
- Sudden gush or leakage of amniotic fluid

Additional conditions – phlebitis, thrombosis, or suspected clotting conditions, any kidney, liver or spleen compromise or infection. Local massage on areas with severe varicose veins and swelling are avoided due to clotting risk.

Prenatal High-Risk Pregnancies It is a strict policy of Brain and Body Therapy to require a doctor's release form in order to receive massage therapy during a High-Risk Pregnancy, which includes, but is not limited to:

- Early labor, miscarriage threat, placental or cervical dysfunction
- Gestational Edema Proteinuria Hypertension (GEPH)
- Preeclampsia
- Gestational Diabetes
- Pre-existing cardiac, renal, connective tissue or liver disorders/diseases
- Fetal genetic disorders
- Complications in previous pregnancies
- 3 or more miscarriages

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Medical History

Due Date: _____

I am _____(number of) weeks into my _____ (1st, 2nd, 3rd) trimester.

Is your pregnancy considered to be high risk? □ Yes □ No (if yes, please explain)

_____

_____

_____

Any complications or problems in this pregnancy? □ Yes □ No (if yes, please explain)

_____

_____

_____

_____

Please List Any Known Diagnoses Date of Diagnosis

_____

_____

_____

Current Medications	Treating for..	Dosage	AM/PM

Are there other areas in your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you?

_____

_____

_____

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Therapy Focus

Do you exercise? □ Yes □ No If yes, how many times per week? _____ For how long? _____

Have you ever experienced massage before: □ Yes □ No

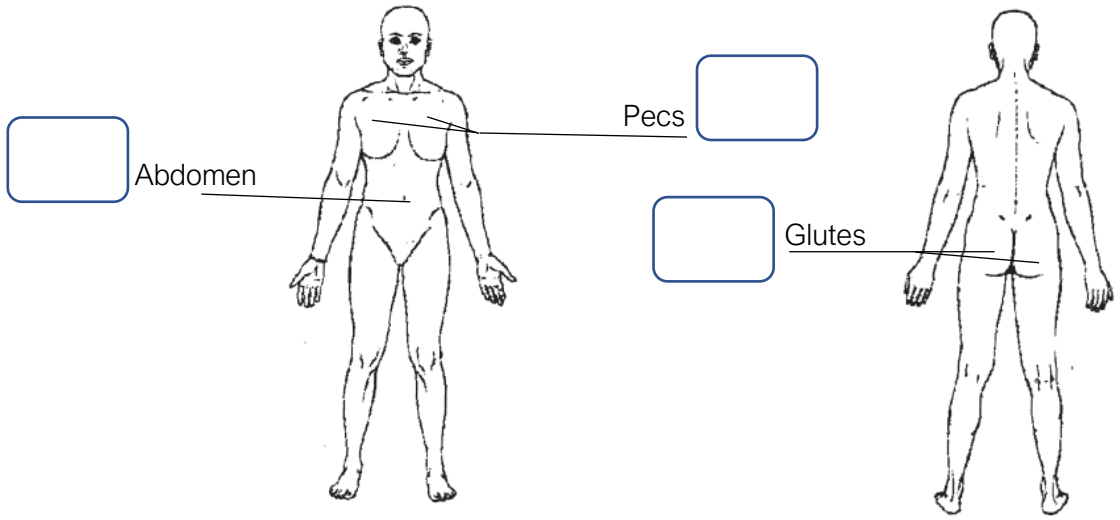
Have you ever experienced a *pregnancy massage* before: □ Yes □ No

Do you have any known allergens to oils/lotions? □ Yes □ No If yes, please explain: _____

Please initial next the following statement:

_____ I agree to have the massage therapist work on my head/neck, back, arms, hands, legs, and feet.

Please initial in the box next to each area you allow permission for the massage therapist to work on:



Please specify any areas which you do not want worked on: _____

What are your primary goals for therapy?

_____

_____

_____

Are there specific target areas you would like the massage therapist to focus on?

_____

_____

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HIPAA Privacy Authorization Form

Effect Date (today's date): _____

Authorization for Use or Discussion of Protected Health Information (required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization. I authorize Brain and Body Therapy (healthcare provider) to use and disclose the protected health information described below to any medical entities as needed.
2. Effective Period. This authorization covers all past, present, and future period of health care.
3. Extent of Authorization. I authorize the release of my complete health record.
4. Use. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation or other purposes as I may direct.
5. Termination. This authorization shall be in force and effect until 2 years from effect date at which time this authorization form expires.
6. Revocation Rights. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already active in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim
7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. Disclosure. I understand that Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name: _____

Signature (or Personal Representative): _____

Date: _____

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Consent to Treat

I hereby certify that I am pregnant and am medically fit to receive massage services. I certify that:

- I have provided Brain and Body Therapy with my full medical history. I will inform my therapist of any medical changes.
- I will inform the therapist so that the pressure and/or strokes me be adjusted for my comfort.
- I acknowledge that massage and bodywork by Brain and Body Therapy should not be construed as a subsidize for medical examination, diagnosis, or treatment and that I should see my primary care provider, a physician, chiropractor, or other qualified medical specialist of a mental or physical ailment that I am aware of.
- I acknowledge that Brain and Body Therapy may bring in equipment into my household as part of the treatment session which includes but not limited to: massage table, massage chair, linens, bolsters, Bal-A-Vis-X (BAVX) equipment. I am responsible for any damage done to equipment by individuals outside of the scheduled client (pets, other children, etc.).
- In the event I need medical assistance (Heimlich maneuver, CPR, etc.) or require medical equipment (inhaler, EpiPen, etc.) I will provide item whereabouts and demonstration proper item usage. I give permission to the treating therapist to utilize his/her professional judgement to intervene in event of medical necessity.
- I will provide payment at time of service.
- I hereby waive and release the massage therapist and associated business from any and all rights and claims for damages that may occur during or after the treatment session.

I hereby certify that the above statements are true and correct.

I _____ (print name) request and consent to be treated.

Signature: _____ Date: _____