PREGNANCY MASSAGE QUESTIONNAIRE

Name:_____

Date: _____ Delivery Due Date: _____

Name of Obstetrician/Midwife? _____

Phone:_____

Please describe how you have felt (physically and emotionally) during this pregnancy:

_____

_____

_____

_____

Have you had any complications or abnormalities? _____ If yes, please describe:

_____

_____

_____

If yes, do you have the approval of your midwife or physician to receive massage? _____

Do you have any of the following conditions or symptoms?

- High Blood Pressure Abdominal Pain (or unusual pain else where in your body)
- Preterm Labor Diarrhea
- Toxemia/Preeclampsia Decreased Fetal Movement in past 24 hours
- Diabetes Excessive Swelling of Hands, Legs and/or Face
- Fever Varicose Veins
- Vaginal Bleeding &/or Abnormal Discharge

(The above conditions are contraindicated for massage – If you marked any of them your therapist may need the approval of your physician to continue or may not be able to work on you at this time.)

Have you eaten within the last 3 hours?

_____

Are you experiencing any tension or soreness in your muscles at this time?

_____

If yes, please describe:

_____

_____

Are you sensitive to any scents or smells?

_____

Would you like to have your abdomen massaged? yes no

Is there anything else you would like to discuss about your pregnancy?

_____

The above information is accurate and true to the best of my knowledge. I understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for updating my practitioner to any physical, mental or emotional changes that occur with my health during my pregnancy. I agree that I am seeking massage voluntarily for treatment of mild discomfort due to pregnancy and/ or relaxation to me and my baby. Any other reason or intention I have for seeking massage during pregnancy I have discussed with my therapist; and I have disclosed all information that may relate.

Signature:_____