Please check any of the following that you are currently experiencing or have previously had in this pregnancy or postpartum time.

- ❑Anemia
- ❑Constipation
- ❑Diastasis Recti (split Abdominal Muscle)
- ❑Edema
- ❑Foot Pain
- ❑Headaches
- ❑Hemorrhoids
- ❑Hiatal Hernia
- ❑Indigestion
- ❑Leg/Foot Cramps
- ❑Low Back Pain
- ❑Mid Back Pain
- ❑Sinus Congestion
- ❑Nausea
- ❑Numbness/Tingling in Hands
- ❑Painful Urination
- ❑Pelvic Pain
- ❑Pelvic Floor Stress Incontinence
- ❑Rib Pain
- ❑Sciatic-Like Pain
- ❑Shortness of Breath
- ❑Spider Veins
- ❑Stretch Marks
- ❑Upper Back Pain
- ❑Uterine Ligament Pain
- ❑Varicose Veins
- ❑Vomiting
- ❑Other_____

Have you ever been diagnosed with a complication or high-risk condition in this or a previous pregnancy? ❑Yes ❑No If yes, please check any that apply below.

- ❑Antepartal Bleeding
- ❑Asthma
- ❑Connective Tissue Disorder
- ❑DES (Disthylstilbesterol) Exposure
- ❑Diabetes
- ❑Gestational Diabetes
- ❑Heart Disease
- ❑Hyperemesis Gravidarum (Severe Morning Sickness)
- ❑Hypertensive Disorder
  - Chronic Hypertension
  - Pregnancy Induced Hypertension
  - Preeclampsia
  - Eclampsia
- ❑Incompetent Cervix Cerclage ❑Yes ❑No
- ❑Infectious Disease
- ❑Intrauterine Growth Retardation
- ❑Kidney Disease
- ❑Repeat Miscarriages
- ❑Oligohydramnios (Decreased Amniotic Fluid)
- ❑Placental Previa
- ❑Polyhydramnios (Increased Amniotic Fluid)
- ❑Preterm Labor
- ❑Renal Disease
- ❑Rh Incompatibility
- ❑Sexually Transmitted Disease
- ❑Substance Abuse
- ❑Teratogen Exposure
- ❑Thrombophilia
- ❑Thyroid Disease
- ❑Urinary Tract Infection
- ❑Other_____
- ❑Other_____

Please provide the following information about your prenatal/postpartum care provider (physician and /or midwife) and include the name and group practice, if applicable.

Prenatal Care Provider_____ Group Name _____

Complete Address_____

Phone Number_____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. I affirm that I have stated all my medical conditions, and answered all questions honestly. I agree to keep my massage therapist updated as to my changes in my medical profile and understand that there shall be no liability on the therapists part should I fail to do so. I also give my therapist permission to consult my prenatal/postpartum care provider regarding my health and treatment. I understand that there is a 24-hour cancellation policy and will give advanced notice if I need to reschedule an appointment in the future.

Your Signature_____ Date _____