KMS Massage & Holistic Therapies, LLC

Pregnancy Client Health History Form

Date_____

Full Name_____

Email Address_____

Address_____

City_____State_____Zip_____

Phone Number_____Cell_____

Date of Birth_____Occupation_____Employer_____

Referred By_____How did you hear of me?_____

Previous experience with massages_____

Primary reason for appointment (ie, areas of pain or tension)_____

Emergency Contact (EC)_____

Phone & Relationship with EC_____

Prenatal Care Provider/Doctor_____

Prenatal Care Provider/Doctor's Phone Number_____

May I have permission to contact your Care Provider (if necessary)? YES NO

My due date is_____

This is my_____(number 1st, 2nd, etc.) pregnancy. This will be my_____(number 1st, 2nd…) birth.

I am_____(number) weeks pregnant in my_____(1st, 2nd, 3rd) trimester.

Please mark **(X)** all conditions that apply **NOW,** mark **(P)** for **PAST** conditions:

_____**Abdominal Cramping ***	_____**Leaking Amniotic Fluid ***	_____**Bladder Infection***
_____**Uterint Bleeding***	_____**Blood Clots/Phlebitis***	_____**Chronic Hypertension***
_____**Pre-Eclamsia (toxemia)***	_____**Pre-term Labor***	_____**Miscarriage***
_____**Problems with Placenta***	_____**Twins or more!***	_____**High/Low Blood Pressure***

_____**Visual Disturbances***	_____Headaches/Migraines	_____Sinus Problems
_____Hernia	_____Nausea	_____Vision Problems/Contacts
_____Dental Bridges/TMJ	_____Abdominal/Digestive Issues	_____Hearing Problems/Deafness
_____Asthma	_____Chronic Pain	_____Injuries to Face or Head
_____Constipation/Diarrhea	_____Muscle or Joint Pain	_____Muscle/Bone Injuries
_____Numbness/Tingling	_____Sprains/Strains	_____Arthritis/Tendonitis
_____Cancer/Tumor	_____Diabetes (gestational or mellitus)	
_____Fatigue	_____Heart/Circulatory Problems	_____Tension/Stress
_____Depression	_____Sleep Difficulties	_____Allergies/Sensitivity
_____Rash/Athletes Foot	_____Infectious Disease	_____Gout
_____Varicose Veins	_____Anemia	_____Car Accident /Trauma
_____Ruptured/Bulging Disc	_____Auto Immune Disorder	_____Fibromyalgia
_____Osteoporosis	_____Emphysema	_____Implants
_____Pacemaker	_____Other:_____	

Explain any conditions marked above:_____

_____

*Any other conditions or problems in current or past pregnancy:_____

_____

Previous surgeries with an approximate date:_____

_____

Previous injuries, including broken bones, not requiring surgery:_____

_____

Medications:

_____Vitamins _____Herbs _____Pain Reducers _____Anti-anxiety

_____Sleeping Pills _____Anti-depressants _____Muscle Relaxants

Other:_____

What are your most frequent activities at work & home? Sitting Standing Lifting

Healthy diet? Always Frequently Sometimes Infrequently Rarely

Adequate Sleep? Every Night Most Nights Difficulty Sleeping Use Sleep Aids

Informed Consent: ***Please take a moment to carefully read the following and sign where indicated.***

I am experiencing a **low risk / high risk** (*circle one*) pregnancy according to my doctor/midwife. If I am currently having or develop complications (any conditions/symptoms listed above with *****), I will discuss the condition with my massage therapist, and will have a medical release for massage signed by my prenatal care provider before continuing therapeutic massage.

The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. Since massage is contraindicated for some serious medical conditions, it may be necessary to obtain a doctor's release or prescription before beginning therapy. I agree to inform the therapist of any experience of pain during the session. I understand massage does not deter me from seeking medical treatment for medical conditions. I understand that no inappropriate comments or conduct will be tolerated. Any indication of such behavior will automatically end the session with full payment.
I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so. I agree to hold harmless the establishment, all management, including volunteers, from and against any and all claims. I agree to handle suit at its sole expense and agree to bear all costs related even if claims, etc., are groundless, false, and fraudulent.

If I am using an expired Gift Certificate, I understand that 10% per month past expiration date will be deducted from total of gift certificate, and balance will be due upon redemption of service. Lastly, should I have to cancel an appointment for any reason I agree to give the therapist a 24-hour notice. Failure to do so may result in a charge to my credit card. Failure to do so three (3) consecutive times will result in prepayment or failure to book any future appointments. I agree and fully understand the above information and consent. _____ Initial

Client Signature_____Date_____

Therapist Signature_____Date_____