

Massage Therapy Pre-natal Massage Form
Atwell Family Chiropractic
1811 Virginia Avenue, Harrisonburg, VA 22802

Please fill out the following information. Please print clearly.

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ E-mail Address: _____
Employer: _____ Occupation: _____
How did you hear about us or who may we thank for referring you? _____

Obstetrician or Midwife's Name and Contact Information:

May I contact him/her, in case of an emergency or if the need arises? _____

Gestational Age: _____
Estimated Due Date: _____
Any previous pregnancies or miscarriages:

If you are currently have or had any of the following conditions, please check and circle them below and discuss them with your
massage therapist before your massage begins.

Please also inform your massage therapist if you are currently under medical care or taking any medications.

Medical History

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Disease/Stroke/Heart Attack | <input type="checkbox"/> Osteoporosis/Scoliosis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Herniated or Ruptured Disc | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Phlebitis/Blood clot/DVT | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Fibrosis |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Inner Ear Problems | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Cancer/Malignancy/Tumor | <input type="checkbox"/> Skin Sensitivity | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures/Fainting Spells | <input type="checkbox"/> Joint Pain/Replacement/Dislocation | <input type="checkbox"/> Nausea/Heart Burn |
| <input type="checkbox"/> Tendonitis/Bursitis | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Inflammation |
| <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Recent Sprains/Strains | <input type="checkbox"/> TMJ Syndrome |
| <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> Cortisone Injection | <input type="checkbox"/> Bed Sores |
| <input type="checkbox"/> Fibromyalgia/Chronic Fatigue Syndrome | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Keloid Scars | | |
| <input type="checkbox"/> Other (Please List) | | |

Any recent surgeries, injuries, accidents or traumas within the past 5 years?

Do you experience any difficulty lying on either of your sides?

Are you allergic or sensitive to any oils or fragrances? If yes, please list. _____

Please list any specific pain or discomforts you have been experiencing.

Please list any prescriptions, herbs or over-the-counter drugs you are currently taking.

Are you under a doctor's care for any reason other than the pregnancy?

May I have speak with your Doctor if the need arises? _____

Physician's name and phone number: _____

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

The information I have provided is accurate and complete to the best of my knowledge. I understand that this work does not constitute medical treatment, but rather is a form of health maintenance utilizing the techniques and principles of traditional Swedish massage, Deep Tissue Therapy, Myofascial Release and Acupressure alternated safely for Pre-natal Massage . I take responsibility for alerting my massage therapist to any physical conditions that would affect this treatment or of any changes in my health status, medications and therapies before the session or any future sessions.

I understand that if I am unable to keep my scheduled appointment, I must give at least 24 hour notice or I will be charged the fee for the treatment I am canceling. I also understand that if I am running late for my scheduled appointment, the amount of time that I am late will be deducted from my treatment time and I will be charged the full amount.

Signed _____ Date _____