

Pregnancy Intake Form (High Risk)

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Name: _____

Date: _____

The therapies administered or ideas offered in this office are in no way intended as a substitute for medical treatment or counseling. To reduce your risk of complications, it is imperative that you consult with your physician and/or midwife. If you have not already done so, please provide me with a written note from your health care provider indicating that you are having a normal pregnancy.

Name of obstetric care provider _____

Name of clinic _____

Address _____

Phone number _____ Fax Number _____

Week of pregnancy _____ Due Date _____ Current Weight _____ lbs.

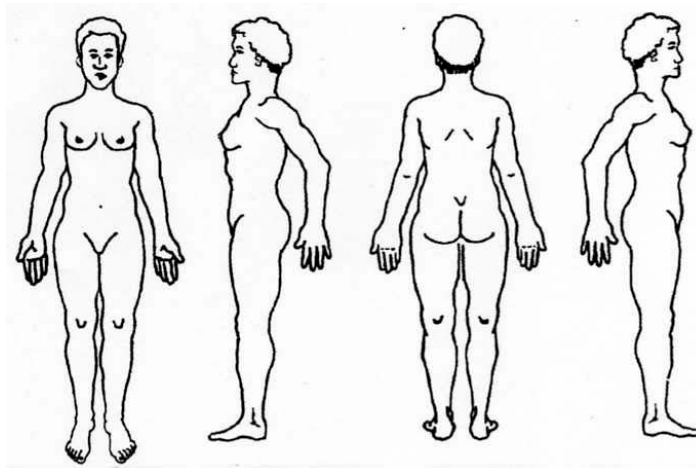
Please check off any of the following that pertain to you:

- | | |
|--|--|
| <input type="checkbox"/> Am over 36 years old | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> First pregnancy | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Pregnant with multiples (2+) | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Morning sickness, vomiting, or nausea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Leg cramps or restless legs |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Placental dysfunction | <input type="checkbox"/> Bladder or kidney infection |
| <input type="checkbox"/> Swollen feet and/or hands | <input type="checkbox"/> Pre-eclampsia |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Premature labor |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Threatened miscarriage |

List any physical disabilities, ailments, allergies, etc. that are not mentioned above:

My goals for this massage:

Please mark the areas where you have tension, discomfort, or pain:



I hereby give permission to Ann Scarborough, Licensed Massage Therapist, to apply massage.

Signature _____ Date _____

**PREGNANCY MASSAGE INFORMATION
AND INFORMED CONSENT**

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Massage during pregnancy provides many benefits proven by research. Massage enhances circulation, supporting the work of your heart, and increasing the oxygen and nutrients delivered to your baby. It can relieve the sensation of heaviness and aching in your legs caused by swelling or varicose veins. It can optimize your muscle tone and function, relieve muscle strain and fatigue, and reduce strain on your joints. Pregnancy massage reduces the stress hormones that negatively affect you AND your baby; and promotes relaxation, contributing to a healthier pregnancy. If you have been told your pregnancy is high-risk, please notify the therapist.

Please read and sign the acknowledgement below:

I have received and read written information concerning the possible benefits of massage therapy during pregnancy. I verify that I am experiencing a low risk pregnancy, and have stated all my known medical conditions. I understand that I will be receiving massage therapy for the purpose of stress reduction, relief from muscle tension or spasm, or for improving circulation and energy flow. I understand that the massage therapist does not diagnose illness, and, as such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I am aware that this massage is not a substitute for medical examination/diagnosis and that it is recommended that I see a physician for any ailment that I might have. I understand and agree that I am receiving massage therapy entirely at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I HEREBY HOLD HARMLESS AND INDEMNIFY the therapist, their principals, and agents from all claims and liability whatsoever.

Printed name: _____

Signature: _____ Date: _____

**PHYSICIAN'S RELEASE FOR THERAPEUTIC MASSAGE
(DURING HIGH-RISK PREGNANCY)**

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From: Ann Scarborough, BA, LMT

_____ (patient's name)
has requested therapeutic massage. These services are provided as adjunctive health care. When a woman's pregnancy is high risk, or she has experienced complications in her pregnancy, it is our policy to work with her only if her primary physician has reviewed this request. Please verify your clearance of this request by your signature below. Please also list any precautions or limitations which you feel to be appropriate.
Thank you for your assistance.

Precautions: _____

Limitations: _____

Printed name: _____

Signature: _____

Date: _____ Phone number: _____



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