Pregnancy Health History Form:

Date:_____/_____/_____

Last name: _____First name:_____

Preferred name:_____Contact number: _____

Date of birth: _____ Occupation: _____

Emergency name & contact number: _____How did you hear about us? _____

Are you on any medication/s? _____ If yes, which ones? _____

Do you exercise? _____ How many times per week? _____ For how long? _____

Please list and explain other conditions/symptoms you are or have experienced:

Have you had any serious or chronic illness, operations, or traumatic accidents? If yes, please explain:

Pregnancy Health History Form:

Please check (√) current problems, mark with (P) if you had in the past :

	abdominal cramping *		preeclampsia (toxemia) *		carpal tunnel syndrome
	bladder infection *		problems with placenta *		allergy to nut oils
	blood clot or phlebitis *		contagious conditions		anemia
	chronic hypertension *		diabetes (gestational or mellitus)		arthritis
	high blood pressure *		hypo or hyperglycemia		bursitis
	leaking amniotic fluid *		low blood pressure		edema/swelling
	miscarriage *		muscle sprain / strain		fatigue
	pre-term labor *		previous cesarean birth		heart attack / stroke
	twins or more! *		separation of the rectus muscles		headaches
	uterine bleeding *		separation of the symphysis pubis		insomnia
	visual disturbances *		skin disorders/ athletes foot		leg cramps

Other conditions or problems in current or past pregnancy

Anything else you would like me to know?

Prenatal Care Provider/Doctor_____ Telephone _____

May I have permission to contact your Care Provider? _____

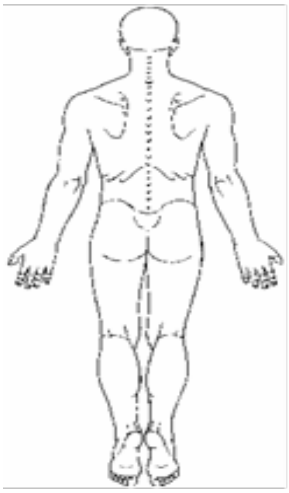
My due date is_____

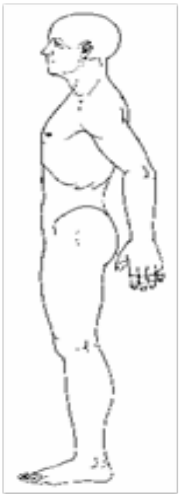
This is my _____(number 1st, 2nd, etc.) pregnancy.

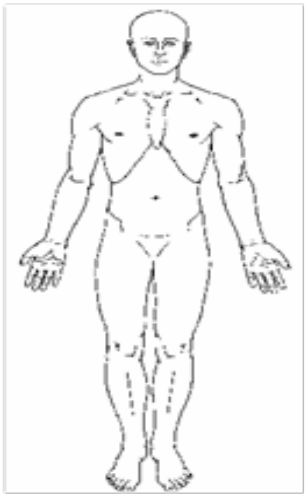
This will be my_____ (number 1st, 2nd…) birth.

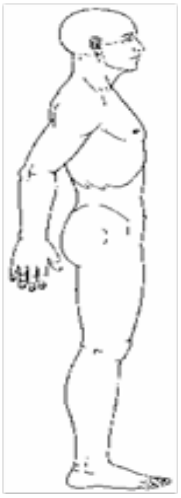
I am _____(number) weeks pregnant in my _____ (1st, 2nd, 3rd) trimester

Mark areas of complaint (if any).









Therapists Notes:

Informed Consent to Massage

FLOURISH
WELLNESS

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension.

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 bodywork signed by my prenatal care provider before continuing bodywork.

I have completed this health form to the best of my knowledge. Massage/bodywork is not a substitute for medical attention administered by a medical or allied health specialist (physiotherapy, osteopathy, chiropractic). If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure/strokes may be adjusted. If I have any questions regarding my session, I will raise them. In addition, if I am uncomfortable for any reason, I may ask that the session be immediately stopped.

I understand and agree to not book in a massage treatment within 4 weeks of receiving a Covid 19 vaccination.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date. Any cancellation within 24 hours is subject to full appointment fees.

Name (signature) _____ Date _____