



Massage Client Information: _____ Date: _____

Name: _____ DOB: _____

Address: _____ City/State _____ Zip _____

Phone(s): _____

Due Date (if pregnant): _____ Delivery Date (if already delivered): _____

Email Address: _____ Opt in ___ Opt out ___

Please indicate if you would like to receive e-mails about special events, classes and newsletters

Physician's/Midwife's Name: _____

How did you hear about The Motherhood Center? ___Website ___Friend ___Advertisement
___Other _____ ___Referred by: _____

Please indicate all that apply. This information is completely confidential and may be important in your treatment.

- | | | |
|--|--|--|
| <input type="checkbox"/> pregnancy (currently) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> back/neck injuries | <input type="checkbox"/> asthma | <input type="checkbox"/> fractures |
| <input type="checkbox"/> pulled muscles | <input type="checkbox"/> dislocations | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> surgery in past year | <input type="checkbox"/> headaches/migraines | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> insomnia | <input type="checkbox"/> irritability |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> indigestion | <input type="checkbox"/> IBS symptoms |
| <input type="checkbox"/> jaw/mouth pain | <input type="checkbox"/> allergies | <input type="checkbox"/> food cravings |
| <input type="checkbox"/> menstrual problems | <input type="checkbox"/> menopause symptoms | <input type="checkbox"/> bruise easily |
| <input type="checkbox"/> other _____ | | |

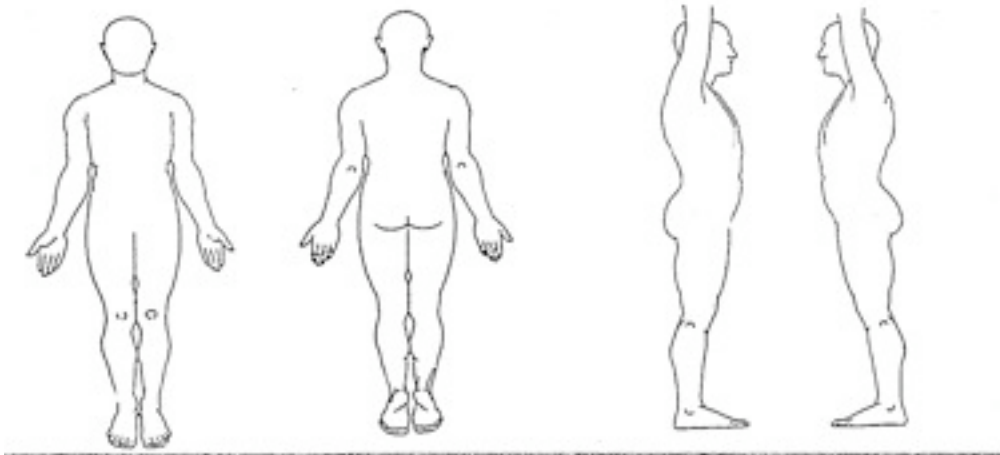
PREGNANT CLIENTS:

Are you experiencing any difficulties or problems in your pregnancy; such as leg cramps, gestational diabetes, high blood pressure, nausea, etc? Please list and be specific:

Do you have any chronic medical conditions? If so, please describe. ___Yes ___No

Please list any medications and supplements you are taking:

Please indicate any areas where you have tension or pain, including areas you would like your therapist to focus on during your massage:



- Neck and Shoulders
- Arms/Hands
- Back of Legs
- Front of Legs
- Feet
- Gluteus Muscles
- Lower back
- Scalp
- Face

Are there any areas you would like your therapist to avoid during your massage?

What type of pressure do you normally prefer? Light Medium Deep

Please indicate the reasons for seeking a massage today:

- Stress Relief
- Relaxation
- Pain/Muscle Soreness
- Other _____

Please list your sports and activities:

Do you have any other conditions or concerns the therapist needs to know about?

Massage Client Release:

By signing this agreement, I hereby agree that I understand that I will be participating in massage therapy as a form of adjunctive health care and that it is my responsibility to consult with a physician prior to participating in the massage. I also understand that breast massage will not be engaged in without my written consent and that proper draping will be used throughout the entire massage. If at any time during the massage I feel uncomfortable, for any reason, I may terminate the massage and my massage session will end. I represent that I am physically fit and if pregnant, that my pregnancy has been progressing normally and that I have my healthcare provider's permission to receive a pregnancy massage. I have no medical condition that would prevent my participation in the massage.

Client Signature

Date

Massage Therapist Signature