GLOW, LLC Client Intake Form – PREGNANCY MASSAGE

Personal Information:

Name____ Date of Visit _______________

Phone (home) ______________ (mobile) ____________ Email __________________________

Address ____

City/State/Zip ____

Date of Birth ___________________________ Occupation _________________________

Emergency Contact _________________________________ Phone _________________

How would you prefer to be contacted for appointment confirmations or cancellations? ________

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Have you had a professional pregnancy massage before? Yes No

If yes, how often do you receive massage therapy? ____________________________

Do you have any allergies/aversions to oils, lotions, or ointments? Yes No

If yes, please explain. ____

Do you have sensitive skin? Yes No

Are you wearing contact lenses ( ), a hearing aid ( ) ?

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe. ____

Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe. ____

Does stress in your work, family, or other aspects of your life affect your life in the following ways?

muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _________________

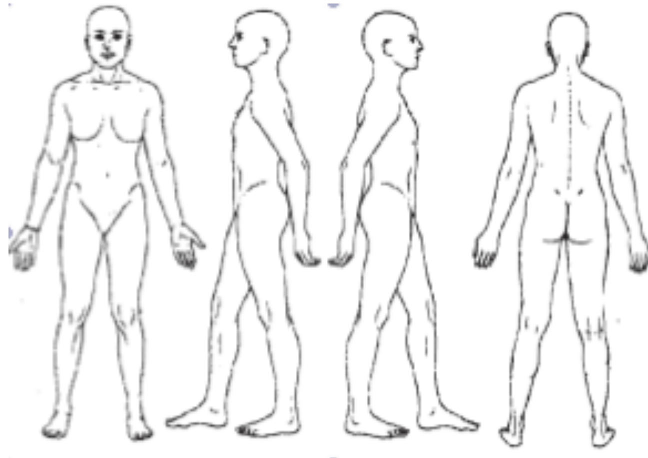
Is there an area where you are experiencing tension, stiffness, pain, or discomfort? Yes No

If yes, please identify. ____

Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain. ____

Please circle any specific areas you would like the massage therapist to concentrate on during the session.



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Pregnancy History

General information about your pregnancy/health history is helpful in planning a massage session that is safe and effective.

What week/month are you in this pregnancy?____________________________________

What is your due date? ____

Who is your prenatal healthcare provider?____________________________________

What number pregnancy is this for you?____________________________________

How many children do you already have and what are their ages?__________________________

Briefly explain any history of miscarriage:____________________________________

Briefly explain any history of fertility issues:____________________________________

Are you currently taking any medications? Yes No

If yes, please list. ____

Please check any health condition listed below (or add) that applies to you in your past or present:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( )back/neck problems
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/tendonitis
( ) osteoarthritis
( ) osteoporosis
( ) rheumatoid arthritis
( ) headaches/migraine
( ) epilepsy
( ) diabetes
( ) cancer
( ) decreased sensation
( ) fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) prenatal or postpartum depression

Please explain any condition that you have marked above.

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Is there anything else about your pregnancy that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

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Draping will be used during the session – only the area being worked on will be uncovered.
Informed written consent must be provided by a parent or legal guardian for any client under the age of 18.

I, ________________________________ [print name], understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep GLOW, LLC or the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

GLOW Cancellation Policy: 24 hour notice is required for any appointment cancellations or changes. With the exception of unexpected illness or emergency, full payment is expected for missed appointments with less than 24 hours notice. **Payment Policy**: Full payment is required at time of service

Signature of Client ____________________________________ Date __________

Signature of Massage Therapist ____________________________ Date __________