PRE & PERINATAL MASSAGE CLIENT INFORMATION

Name _____ Age _____ Date _____

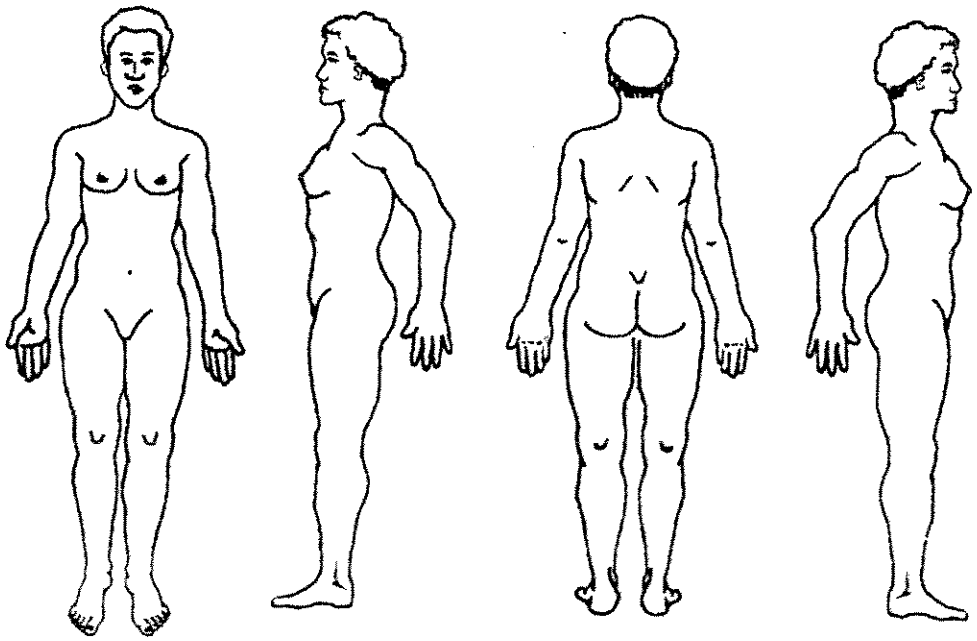
Week of Pregnancy _____ Expected Due Date _____

Physician _____

Please check any complication or condition you may have experienced in this pregnancy:

_____ bladder infection
_____ constipation
_____ difficulty sleeping
_____ gestational diabetes
_____ headaches
_____ heart disease
_____ heartburn
_____ hemorrhoids
_____ high blood pressure
_____ indigestion
_____ leg cramps
_____ multiple pregnancy (twins)
_____ phlebitis
_____ placental dysfunction
_____ pre-eclampsia
_____ premature labor
_____ restless legs
_____ swollen hands and/or feet
_____ threatened miscarriage
_____ varicose veins

Please indicate any areas where you have tension, discomfort, or pain:



Is there any area on which you particularly want to focus in your massage session?
Is there anything else you want me to know about your health or pregnancy?

_____

_____

_____