

Pregnancy Massage Therapy Intake Form

Date: ___ / ___ / ___ Name: _____

Date of Birth: ___ / ___ / ___ Social Security Number: ___ - ___ - ___

Street Address: _____ City: _____ State: ___ Zip: _____

Home Phone #:(____) ___ - ___ Work#:(____) ___ - ___ Cell#:(____) ___ - ___

Occupation: _____ Referred by: _____

Does It Involve Long Periods of: Sitting Standing Computer Work Other _____

Have You Ever Received Massage Therapy: YES NO When: _____

Type of Massage Experienced: Deep Tissue Swedish Other _____

Have You Experienced a Pregnancy Massage Before? YES NO

Are You Taking Medication: YES NO If So, Describe: _____

Duration of Pregnancy: _____ weeks Expected Due Date _____

of Pregnancies: _____ # of Births _____ Prenatal Care Provider _____

Do You Currently Have Any Areas of Discomfort? YES NO

If Yes, What Are They? _____

Do You Have Any Past Injuries or Surgeries That I Should Know About? YES NO

If Yes, What Are They? _____

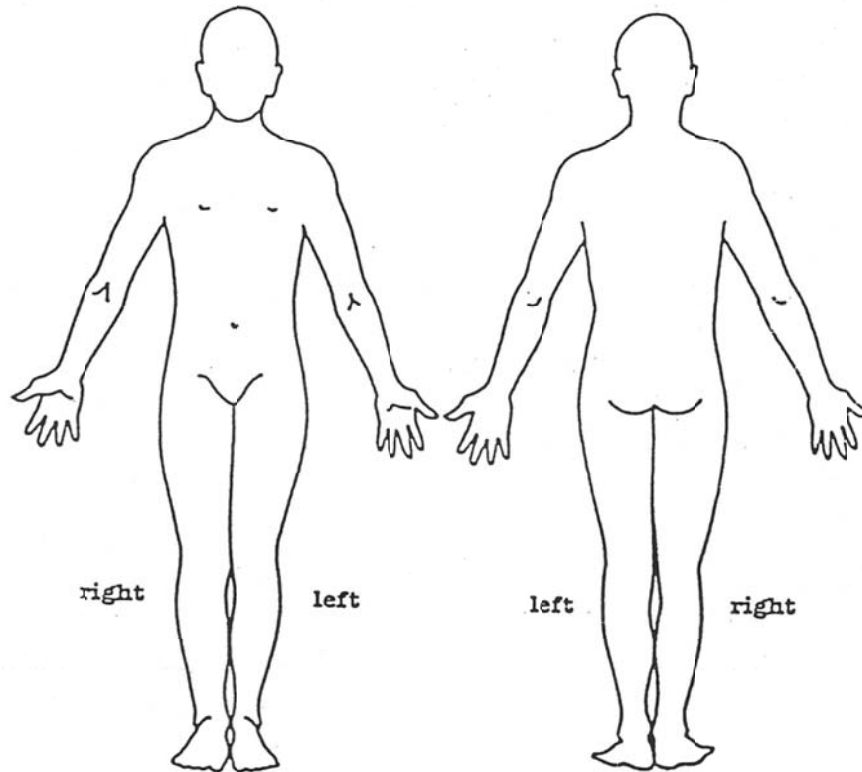
When Do You Plan to Begin Maternity Leave? _____

Do You Have a History of the Following? (Please check all that apply)

- | | | | |
|---|---|--|------------------------------------|
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Morning Sickness/Nausea | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Pre-Term Labor | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heartburn | | | |

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Indicate with an "X" where it hurts most, "O" for mild pain



CLIENT AGREEMENT

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension, or therapeutic applications. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage/bodywork 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(s) given should be construed as such.

Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the "full" scheduled appointment.

Signed: _____ Date: _____

Practitioner: _____ Date: _____