Perinatal Health LLC
Intake Form

Name_____ Birth Date_____

Address_____ Telephone _____

City_____State_____Zip_____

Email_____

Occupation_____

Emergency phone contact:

Name_____ Phone _____

How did you learn about Perinatal Health LLC?
_____

Are you taking medication? _____ If yes _____

Do you exercise? _____ How often? _____

Please list and explain other conditions/symptoms you are or have experienced with this pregnancy_____
_____
_____
_____
_____

Have you had any serious or chronic illness, operations, or trauma?
_____
_____

Doctor/Midwife_____Telephone_____

Provider address_____

May I have permission to contact your care provider? _____

My due date is_____ This is my _____ (1st, 2d, etc.) pregnancy.

Are you having multiples? _____

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Please indicate and explain what conditions you presently have or had in the past.

Abdominal cramping_____

Allergies (grapeseed or nuts) _____

Amniotic fluid leakage_____

Anemia_____

Anxiety _____

Arthritis_____

Athletes foot_____

Back pain (lumbar, thoracic, cervical) _____

Blood clot_____

Carpal tunnel syndrome_____

Cesarean birth (how many) _____ _____

Contagious conditions please explain_____

Depression_____

Diabetes (gestational or mellitus) _____

DVT _____

Edema or Swelling _____

Headaches _____

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continued

Hypotension_____

Hypertension chronic_____

Infections_____

Joint Pain_____

Leg cramps_____

Migraine_____

Nausea_____

Numbness_____

Phlibitis_____

Placenta Previa_____

Plantar warts_____

Preclampsia_____

Pre term labor _____

Separation of the pubis symphysis_____

Separation of the rectus muscles_____

Skin Disorders_____

Sciatic_____

Uterine bleeding_____

Varicose veins_____

Vomiting_____

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Please list any current or previous conditions around your pregnancy that you would like to discuss.

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Informed Consent Agreement

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 symptoms/conditions 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 will immediately let my therapist know of any pain or discomfort so that pressure and strokes can be adjusted to my level of comfort.

I understand that the massage given to me by *Perinatal Health LLC* is for the purpose of (stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons stated here_____).

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceutical. I understand that bodywork is a health aid and Does not take the place of a physician's care. Any information exchanged during a massage or bodywork session is confidential and is only used to provide you with the best services. I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I have completed this health form to the best of my knowledge. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided to me by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or Treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient_____Date_____