
Free Spirit Massage & Doula Services, LLC
205-A Old Perry Road, Bonaire, GA 31005
(478) 365-7857
Pregnancy Massage Therapy Intake Form
CONFIDENTIAL INFORMATION

Name _____ Date of birth _____

Address _____ City _____

Zip _____ State _____ Cell Phone _____

Work Phone _____ Occupation _____

Email Address _____

Do you give me permission to contact you? (Check all that apply)

_____ USPS Mail _____ Phone Call _____ Email _____ Text _____ Facebook Messenger

How did you hear about Free Spirit Massage & Doula Services, LLC?

Height _____ Weight (pre-pregnancy) _____ Weight (now) _____

Emergency contact name & number: _____

Week of Pregnancy _____ Expected Due Date _____

Physician Name/Number: _____

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

_____ Multiple pregnancy (twins)

_____ Gestational diabetes

_____ Placental dysfunction

_____ High blood pressure

_____ Pre-eclampsia

_____ Threatened miscarriage

_____ Premature labor

_____ Heart disease

_____ Bladder infection

_____ Swollen hands and/or feet

_____ Varicose veins

_____ Phlebitis

_____ Leg cramps

_____ Restless legs

_____ Headaches

_____ Heartburn

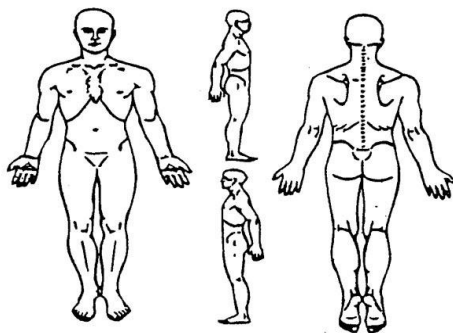
_____ Indigestion

_____ Constipation

_____ Hemorrhoids

_____ Difficulty sleeping

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below. Mark X for pain and 0 for discomfort: _____



Describe any chronic pain/tension _____

What makes it better? _____

What makes it worse? _____

Are you currently under the care of any other physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for?

Please list any medications (prescription or non-prescription), vitamins and supplements you are currently taking:

What specific areas would you like for me to focus on or stay away from? _____

Are there any areas you do NOT like massaged (i.e. feet, stomach, head, face)? _____

What do you hope to accomplish with this massage? (i.e. relaxation, decrease back pain, increase flexibility, etc.)

How frequently and for how long do you exercise and what do you do? Include sports, Pilates, yoga, gardening and/or other physical activities: _____

How many hours of sleep do you receive each night (approximately)? _____

What is your sleeping position? (normally) _____

What is your daily intake of water: _____

Please check any of the following that apply to you in the past or present:

Condition/Complaint	Past	Present	Condition/Complaint	Past	Present
Headaches			Pins and Needles in arms, legs, Hands or feet		
Type:			Neurological problems		
Asthma			Spinal Problems		
Cold Hands/feet			Herniated/Bulging Discs		
Swollen ankles			Osteoarthritis		
Sinus Conditions			Arthritis		
Frequent Colds			Anxiety		
Allergies (specify above)			Depression/Panic		
Skin Conditions			Sleep Disturbance		
Painful/Swollen Joints			Loss of Memory		
Auto-immune disorder			Whiplash		
Cancer			Bruise Easily		
Varicose Veins			Constipation/Diarrhea		
Blood Clots/DVT			Contact Lenses		
Heart Problems			Hemorrhoids		
Pacemaker			Artificial/Missing limbs		
High/Low BP			Muscular Tension		
Diabetes			Sciatica		
Epilepsy or Seizures					

Further explanation of any condition or other information: _____

The following sometimes occurs during massage; they are normal responses to relaxation. Trust your body to express what it needs:

- ☺Need to move or change positions ☺Sighing, yawning ☺Stomach gurgling ☺Memories
- ☺Emotional feelings and/or expressions ☺Movement of intestinal gas ☺Energy shifts ☺Falling asleep

Cancellation/reschedule policy:

Booking a session with me, you agree to my policies. All policies are posted on my website as well.

1. Cancel / reschedule your appointment with at least 24 hours notice: no charge
2. Cancel / reschedule your appointment within 24 hours of your appointment for any reason: 50% of the full un-discounted rate. You can avoid this by sending someone in your place! If you are able to fill this appointment: no charge
3. Cancel / reschedule your appointment within 3 hours: Full charge, unless we can re-book that slot.
4. No show / No notice: If you do not show up for any reason, with no notice, you will be charged full price of the session booked.
5. If you are late for your scheduled session; your session starts without you. You will receive the remaining time you scheduled, but will pay for the full time slot booked. Arrive early so that your session can start on time.
6. Due to recent events with COVID, if you arrive at your appointment showing signs of **ANY** illness, you will be sent home and charged for the appointment. Please call the moment you show signs of illness to avoid any charges.

Signature _____ Date _____

Print Name: _____

Free Spirit Massage & Doula Services, LLC
205-A Old Perry Road, Bonaire, GA 31005
(478) 365-7857

**PREGNANCY MASSAGE INFORMATION
AND INFORMED CONSENT**

I, _____, have received and read the attached written information about the possible contraindications to massage therapy during pregnancy.

I understand and confirm that:

- I have not experienced any of the complications listed on the attached sheet;
- I have not experienced any of the complications listed, which would make it unwise to have massage therapy;
- I am experiencing a low-risk pregnancy;
- I am receiving medical care including regular check-ups throughout my pregnancy.

My physician and I have defined the following exclusions to the above statements: _____

I understand that I will be receiving massage therapy as a form of adjunctive healthcare only and that this therapy is not intended to replace appropriate medical care.

Having been fully advised of the risks, contraindications and complications to massage therapy during pregnancy, I have decided to participate in the therapy. Accordingly, I do forever release the therapist/practitioner and their insurers, and their respective officers, directors, stockholders, successors, employees, and agents from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving massage therapy during this childbearing year.

I further agree to hold harmless and defend the therapist/practitioner of and from all actions, claims and or other legal or administrative action that has arisen or may arise directly from my and my child's participation in this therapy.

Signed: _____ Date: _____

Print name: _____

Benefits of Prenatal Massage

- Relief of muscle tension, spasms, and cramps, specifically in the low back, upper back, shoulder, and neck areas.
- Reduces stress on weight-bearing joints.
- Gestation process is enhanced through increasing blood circulation, lymph circulation, reducing edema, and increasing cellular respiration.
- Stimulates glandular secretions, which helps stabilize hormone levels.
- Enhances body awareness around better posture to lessen discomfort.
- Assists with body mechanics and movements during structural changes happening with the body.
- Supports birth process by relaxing muscles, especially muscles involved in labor and birth.
- Helps maximize breathing capacity needed for labor and delivery.
- Enhances the pliability of skin and underlying tissues.
- Eases anxiety and stress during time of transition.
- Gives emotional support and nurturance.

Contraindications of Prenatal Massage (some may be okay with physician approval)

Specific to Pregnancy

- Gestational Edema Proteinuria Hypertension (GEPH)
- Gestational Diabetes (excessive hunger and thirst; increased urination in 2nd trimester; sugar in urine, no non-pregnant diabetes)
- Early labor, miscarriage threat, previous multiple births, placental or cervical dysfunction
- Mothers under age 20 or over age 35
- Suspected RH Negative or other genetic problems
- Pre-eclampsia or Eclampsia (persistent severe headaches; persistent severe back pain unrelieved by change of position; severe nausea/vomiting; systemic edema; pitted edema, increased blood pressure; visual disturbances; convulsions)

Other Contraindications

- Bloody discharge
- Continual abdominal pains
- Sudden gush or leakage of amniotic fluid
- Incompetent cervix
- Severe anemia
- Sudden, rapid weight loss or gain
- Increased blood pressure or chronic hypertension
- Fever
- Diarrhea
- Excessive swelling in arms or legs
- Increased or decreased fetal movement over a 24-hour period
- Urinary Tract Infections
- Cardiac disorders and heart disease
- Asthma
- Lupus Erythematosus
- Phlebitis
- Thrombosis
- Other clotting conditions
- Any liver, kidney, or spleen compromise or infection
- Local massage over severe varicose veins and inflammation (due to clotting risk)