AMBROSIA
Massage & Bodywork

PRENATAL MASSAGE

Name: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____

Prenatal Provider: _____ Phone: _____

Do you give Ambrosia consent to contact the above listed people and providers? ◯ Yes ◯ No

How far along?: _____ (weeks) Expected due date: _____ ◯ Boy ◯ Girl ◯ Surprise

I have had _____ previous pregnancies and _____ previous births. I am carrying: ◯ One baby ◯ Multiple babies

Are you experiencing a high risk pregnancy? ◯ Yes ◯ No

Have you had a professional massage before? ◯ Yes ◯ No

Have you had a pregnancy massage before? ◯ Yes ◯ No Frequency: _____

Do you take any medications or supplements? ◯ Yes ◯ No Details: _____

Do you have any of the following:

◯ Headaches
◯ Fatigue
◯ Anemia
◯ Blood Clots
◯ Vericose Veins
◯ Edema / Swelling
◯ Leg Cramps
◯ Pinched Nerve
◯ Sciatica
◯ Numbness/Tingling
◯ Muscle Strain/Sprain
◯ Gestational Diabetes
◯ Hypo/Hyperglycemia
◯ High/Low Blood Pressure
◯ Preeclampsia (toxemia)
◯ Pre-term Labor
◯ Miscarriage History
◯ Other:

Please provide any additional details or conditions not listed above: _____

Is there anything else you would like me to know?: _____

_____

_____

_____

Client Signature

_____ _____

Therapist Signature Date

Weeks: Therapist: Date:

S:

O:

A:

P:

Weeks: Therapist: Date:

S:

O:

A:

P:

Weeks: Therapist: Date:

S:

O:

A:

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