Gaealana Healing Arts Center

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Prenatal Client Intake Form

Name: ______________________________ Date : ______________

Referred by: ____

Address:____

Phone: ______________________Email: ___________________

Occupation: ___________________ Birthday: _______________

Emergency Contact:________________ Phone: _______________

Would you like to receive our monthly e-newsletter with special offers? ____yes ____no

Have you received massage therapy before? __________ If so, what type?_________________

Date of LMP:___________ Week of Pregnancy: ____________ Estimated Due Date: ____________

Planned Birth Place: ______________ Prenatal Healthcare Provider: __________________

I have had ___ previous pregnancies and ___ previous births. I'm carrying ___ one baby ___ multiples

Please mark past (p) or current (c) to any conditions that may apply to your experience in this pregnancy:

____ Miscarriage	____Indigestion	____Constipation/Gas	____Anemia
____Still Birth	____Heartburn	____Anxiety/Depression	____Difficulty Sleeping
____Ectopic Pregnancy	____Morning Sickness	____Uterine Abnormalities	____Headaches/Migraines
____High Blood Pressure	____Varicose Veins	____Placenta Previa	____Leg Cramps
____Pain in Pubic Bone	____Edema (Swelling in Hands and/or Feet)	____Placental Abruption	____Low Blood Pressure
____Restricted Breathing		____Gestational Diabetes	____Dizziness/Fainting
____Carpal Tunnel Pain	____Sciatica/Piriformis Syndrome	____Threatened Miscarriage	____Allergies
____Breech Presentation		____ Pre-eclampsia	____Skin Disorders
____Stiffness	____Communicable Disease	____Heart Disease	____Numbness

Are you taking any medications, vitamins, supplements, or remedies?

Please list any surgeries, accidents or major illnesses within the last five years.

Please list the information regarding any hospitalizations.

What do you do to relax? What do you do to exercise?

What are the primary sources of stress in your life? Where in your body do you hold stress?

In regard to previous pregnancies, what was your experience of :

Pregnancy :

Labor & Delivery

____ Vaginal Birth ____ Cesarean Birth ____ Premature ____ Induced Birth

Postpartum:

Breast-feeding

Postpartum Depression/Anxiety :

Is there anything else you would like me to know about your health or pregnancy?

What are your current goals for massage?

Informed Consent and Business Agreement

Full payment is due at the time of treatment. A cancellation must be made 24 hours in advance to avoid charges. You are responsible for half the cost of an appointment cancelled within 24 hours and full price of an appointment missed without cancellation. Payments must be made before receiving further treatment. In the case that you are using health or auto insurance to pay for a portion of your care in this office, arrangements may be made to omit payment and await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to 6 months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize my provider, ______________________________ , to release my medical records relating to claim for benefits submitted.

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I hereby give my consent to receive therapeutic massage.

Signature:____Date:_____________________