PRENATAL PERSONAL INFORMATION & HEALTH HISTORY

DATE:

NAME:
ADDRESS: POSTAL CODE:
PHONE NUMBER (home): (work): (cell phone):
E-MAIL:

EMERGENCY CONTACT NAME: PHONE NUMBER:

REFERRED BY:

HOW MANY WEEKS PREGNANT ARE YOU?

WHAT IS YOUR APPROXIMATE DUE DATE?

WHICH PREGNANCY IS THIS? (please circle) 1 2 3 4 5

WHAT IS YOUR PHYSICIAN OR MIDWIFE'S NAME & PHONE NUMBER?

ARE YOU PLANNING ON HAVING PROFESSIONAL LABOUR SUPPORT (DOULA)?

HAVE YOU EVER RECEIVED MASSAGE THERAPY IN THE PAST? (please circle) YES / NO
FREQUENCY OF TREATMENT:
DATE OF LAST TREATMENT:

WHAT DISCOMFORTS, PAIN OR OTHER NEEDS ARE YOU HOPING TO HAVE ADDRESSED THROUGH MASSAGE THERAPY?

HAVE YOU HAD ANY COMPLICATIONS OR PROBLEMS WITH THIS PREGNANCY?
(please circle those applicable)

- Bleeding, cramping, amniotic fluid leakage
- Water retention, high blood pressure, rapid weight gain, protein in urine
- Vision disturbances
- Severe nausea, vomiting or headache
- Abnormal fetal growth, heart beat or movements
- High blood pressure
- Other (please specify) _____

(over)

DO YOU HAVE ANY EXISTING MEDICAL CONDITIONS?
(please circle those applicable)

- Diabetes
- Heart, lung or kidney disorders
- Convulsive disorders
- Uterine abnormality
- Connective tissue or collagen diseases
- Asthma
- Other (please specify) _____

ARE YOU CURRENTLY EXPERIENCING ANY INFECTION OR DISORDER?
(please circle those applicable)

- Cold
- Bladder infection
- Skin irritation
- Varicose veins
- Other (please specify) _____

IS YOUR PREGNANCY CONSIDERED TO BE HIGH RISK?
(please circle those applicable)

- Diabetes
- High blood pressure
- Multiple pregnancy
- Previous complicated pregnancy
- Asthma
- Rh or genetic problems
- Under 20 or over 35 years old
- Fetal genetic disorders
- Exposure to hazardous material
- Other (please specify) _____

ANY OTHER RELEVANT INFORMATION?