



This form must be submitted 24 hours prior to your session to ensure there are no contraindications that may need further discussion or a doctor's clearance.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Before you receive bodywork, please answer the following questions:**

Were there any complications with your delivery you would like to address? \_\_\_\_\_

Are there specific things you would like addressed in this session?

Sciatic Pain / Stretch Marks / Headaches / Low Back Pain / Upper Back Pain / Swelling

Other: \_\_\_\_\_

If you delivered via caesarean, where are you at in your healing process?

Stitches: Still in / Removed – when \_\_\_\_\_ Scar: red / tender/ inflamed / numb / keloid / tight

Would you like focused work on your scar? Yes / No

Have you had any other surgery within the last 30 – 60 days? \_\_\_\_\_

Do you have Diabetes? Yes / No

Do you have any old or new back injuries unrelated to this pregnancy? (i.e., car accident, etc.)

Do you have any type of heart conditions?

Are you currently taking any medications? If yes, what & what for?

Do you prefer light, moderate, hard-deep pressure during your massage? (circle one)

Do you prefer silence (no talking) during your massage? YES / NO

Is it okay to get oil in your hair and on your face? (for cranial work) YES / NO

Do you have any allergies? (i.e., Eucalyptus or Menthol) YES / NO

Would you like to be placed on a mailing list to receive updated massage information, special offers, etc. via email? YES / NO

I understand that should my condition change in any way I am responsible for notifying my practitioner immediately and I am aware that I may need a doctor's clearance before my practitioner can work with me because of the change in my condition.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_