



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:

What is your Estimated Due Date (EDD)? _____ Who is your doctor? _____

Do you have Diabetes? Yes / No Is it gestational? Yes / No

Have you had surgery within the last 30 – 60 days? Yes / No

If yes, for what? _____

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 medication for depression?

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

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

Other: _____

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: _____