***Hillsborough Massage Therapy*– Prenatal Client Intake Form**

Please PRINT all information

Name: _____ **Expected Delivery Date** _____

Address :_____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Email for Confirmations _____

Preferred Phone #: _____ Secondary Phone #:_____

Occupation/Type of Work: _____

In Case of Emergency, Please Notify: Name: _____

Telephone #:_____ Relationship: _____

Other Information: If employed, what town: _____

Number of Children: _____ Ages: _____

Preferred Appointment Day and Time, if any: _____

How did you hear about us? _____

***Hillsborough Massage Therapy*- Informed Consent**

I, _____, (*client*) understand that massage and bodywork therapy provided by Hillsborough Massage Therapy LLC are intended to promote and maintain the health and well-being of the client. Massage and bodywork therapies do not include the diagnosis of illness, disease, impairment or disability. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or manipulations may be adjusted to my level of comfort.

Because massage and bodywork therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the therapist of all my known medical conditions and will keep the therapist updated as to any changes in my medical condition.

Client Signature_____ Date _____

Parent/Guardian Signature if Under 18:_____ Date: _____

***Hillsborough Massage Therapy*– Health Information**

Do you have any of the following problems or conditions? Please check those that apply.

Anemia _____ Blood Pressure _____ Breathing Problems _____

Contractions _____ Depression _____ Excessive Weight Gain or Loss _____

Gestational Diabetes _____ Morning Sickness _____ Pain _____

Placental Abnormalities _____ Sciatic Pain _____ Spotting _____

Swelling _____ Varicose Veins _____ Other _____

Please describe previous pregnancies and births with dates: _____

_____

Please describe your current pregnancy to date: _____

Where in your body do you currently feel pain, tension or stress?_____

Please list any medications you are taking, including self-prescribed ones: _____

_____

Are you receiving regular prenatal care? _____

Name of Care Provider: _____

Delivery Hospital: _____

Please mark or circle any particular areas of concern. You may wish to describe your concerns, also.