



*PRE & POSTNATAL MASSAGE THERAPY  
CLIENT INTAKE FORM*

Client Name:\_\_\_\_\_ Today's Date:\_\_\_\_\_ Due Date:\_\_\_\_\_

It is my intent to provide you with a safe and nurturing experience during and/or after your pregnancy. There are some conditions I need to be aware of in order to tailor our sessions to the best interest of you and your baby. It is my policy to work with a pregnant or postpartum woman only if her healthcare provider has reviewed and approved of this treatment, so, in addition to completing this form, please have your doctor or midwife fill out a release form.

**General Information**

Massage therapy during pregnancy or postpartum is not intended to replace prenatal or postpartum care. Used as an adjunctive therapy, its potential benefits include:

- Reduced stress
- Increased relaxation
- Regulation of blood pressure
- Relief of muscle spasms, cramps and myofascial pain, especially in the back, neck, hips and legs
- Increased blood and lymph circulation and support of the physiological processes of pregnancy
- Reduced stress on weight-bearing joints and decreased musculoskeletal strain and pain
- Increased emotional support and physical nurturance
- Enhanced kinesthetic awareness and ability to achieve deep relaxation, thereby supporting comfortable structural changes
- Learned labor support techniques through muscle education, kinesthetic awareness and relaxation techniques
- Support of postpartum restoration of abdomen and weight-bearing muscles and joints
- Postpartum support with the physical and emotional aspects of infant care
- Promotion of healing, including post-cesarean scars

Pregnancy massage is beneficial throughout pregnancy, but must be modified for safety according to stage of pregnancy and individual conditions. Labor massage can be given at the discretion of your prenatal healthcare provider. Postpartum massage can begin 24 hours after delivery.

Please have your healthcare provider review this information and the information on page 2 with you, and fill out a separate release. If you have or have had any of the high risk factors, complications, or conditions listed on page 2, please discuss your condition with your prenatal healthcare provider in connection with your interest in receiving prenatal massage. For postpartum appointments in the six-weeks after delivery, if there were complications or a cesarean delivery, you must have written release from your prenatal healthcare provider.

If your healthcare worker would like to speak to me directly about concerns or modifications, please provide him or her with a written release. He or she is welcome to call me at 401-338-5466, or to email [kaeli@motioncenter.com](mailto:kaeli@motioncenter.com). Please bring all releases to your first session.

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page 2.

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High Risk Factors: (please check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Pre-pregnancy diabetes                          | <input type="checkbox"/> Genetic disorder/DES/uterine abnormalities |
| <input type="checkbox"/> Cardiac disorders (heart or pulmonary problems) | <input type="checkbox"/> Multiples (twins, triplets, etc.)          |
| <input type="checkbox"/> Hypertension/high blood pressure                | <input type="checkbox"/> Mother's age under 20 or over 35           |
| <input type="checkbox"/> Thyroid disorder                                | <input type="checkbox"/> Asthma                                     |
| <input type="checkbox"/> RH negative                                     | <input type="checkbox"/> Drug/Alcohol use                           |
| <input type="checkbox"/> Previous complications of pregnancy             | <input type="checkbox"/> Renal/liver/blood/convulsive disorders     |

Pregnancy Complications: (please check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Gestational diabetes               | <input type="checkbox"/> Fetal development complications  |
| <input type="checkbox"/> Threatened miscarriage             | <input type="checkbox"/> Anemia   |
| <input type="checkbox"/> Early labor                        | <input type="checkbox"/> Pregnancy-induced hypertensive disorders<br>(preeclampsia/eclampsia/toxemia) |
| <input type="checkbox"/> Placental dysfunction              | <input type="checkbox"/> Kidney/liver and/or bladder disorders  |
| <input type="checkbox"/> Cesarean birth (recent or planned) |   |

Non-pregnancy related complications: (please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Cancer or undiagnosed lumps | <input type="checkbox"/> Contraindicated for affected areas only:      |
| <input type="checkbox"/> Infection                   | <input type="checkbox"/> Severe varicose veins                         |
| <input type="checkbox"/> Autoimmune disorder         | <input type="checkbox"/> Thrombophlebitis                              |
| <input type="checkbox"/> Musculoskeletal Injury      | <input type="checkbox"/> Skin irritation and/or discharge              |
| <input type="checkbox"/> Other_____                  | <input type="checkbox"/> Fracture, bleeding, burns, other acute injury |

I \_\_\_\_\_ verify that I have been informed of the possible benefits and contraindicated conditions for massage therapy during pregnancy and postpartum. I will discuss with my physician/certified prenatal healthcare provider any health concerns that he or she or I have about massage therapy. I further verify that: (check one)

\_\_\_\_ I have not had nor do I now have any prenatal complications nor any of the conditions listed above.

\_\_\_\_ I have noted on the above list all prenatal complications, risks or conditions I am/have experienced AND I have discussed it with my maternity healthcare provider and obtained his or her release.

I understand that I will be receiving massage therapy and bodywork as a form of adjunctive health care only and that the massage therapy I receive is not a substitute for obstetric prenatal or perinatal care from a medical doctor or other licensed provider.

I hereby release and hold harmless and defend the practitioner from any claims, liability, demands and causes of action arising from my and my child's participation in this therapy.

Signature\_\_\_\_\_ Date\_\_\_\_\_ Printed Name\_\_\_\_\_