PRENATAL INTAKE

Sheila Resari, LMT #12784
www.truenorthmassage.com
3958 NE 7th Ave, Portland, OR 97212
503-880-7977

TRUE NORTH MASSAGE

Name: _____ Birth date: _____

Address: _____ Phone: _____

Email: _____

Occupation: _____ Join our e-mail list: Yes ☐ No ☐

Emergency contact: _____ *Phone:* _____

1. What discomforts, pain, or other needs are you hoping to have addressed through this massage therapy?

2. In what week of pregnancy are you? What is your due date?

3. Are you regularly seeing a physician, midwife, or nurse-midwife?
Name and phone number:
Date of last visit:

4. Have you had any complications or problems with this pregnancy? Circle all that apply:

Bleeding	Rapid weight gain	Protein in urine
Cramping	Vision disturbances	Abnormal fetal growth/heartbeat/movements
Amniotic fluid leakage	Severe nausea	High blood sugar
Water retention	Vomiting	Varicose veins
High blood pressure	Headaches	Other: _____

5. Do you have any medical conditions? Circle all that apply:

Diabetes	Convulsive disorders	Heart/liver/lung/kidney disorders
Uterine abnormality	Connective tissue disease	Collagen disease

Other: _____

6. Are you currently experiencing any infection or disorder? Circle all that apply:

Bladder infection	Skin irritation	Other: _____

7. Is your pregnancy considered high-risk? Circle all that apply:

Diabetes	Hypertension	Multiples (twins, triplets, etc.)
Asthma	Rh/genetic problems	Previous complicated pregnancy
Fetal genetic disorders	Haz-mat exposure	Under 20/Over 35 years old

8. Is there other relevant information about this pregnancy or about you that I should know?

9. I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive massage.

Signature_____ Date: _____