



# Perinatal Massage

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

Expected Due Date \_\_\_\_\_ Is this your first pregnancy massage? Y / N

Number of Pregnancies \_\_\_\_\_ Number of Births \_\_\_\_\_

Daily/Frequent Activities \_\_\_ Standing \_\_\_ Sitting \_\_\_ Driving \_\_\_ Bending \_\_\_ Lifting \_\_\_ Yoga  
\_\_\_ Walking \_\_\_ Running \_\_\_ Swimming \_\_\_ Computer work

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

What is your goal in this Massage Therapy session?

\_\_\_ General Wellness \_\_\_ Relaxation \_\_\_ Decrease muscle pain/stiffness

Other \_\_\_\_\_

What areas need to be focused on? \_\_\_\_\_

Any areas you prefer NOT be massaged? \_\_\_\_\_

Surgeries/Accidents, including year \_\_\_\_\_

\*\*\*By signing and dating this form, you acknowledging that...

- ...the information you have provided is complete and correct. You also agree to inform your Massage Therapist of any changes pertaining to this information.
- ... you have read the Hopewell Center for Perinatal Services Client Policies and agree to abide by them.
- ... you have read and understand your Client Bill of Rights.

Your personal information is protected by the HIPAA law and this office will abide by the law.\*\*\*

Sign \_\_\_\_\_

Date \_\_\_\_\_

Witnessed By \_\_\_\_\_

Date \_\_\_\_\_

Updated 8.19.09