

Utah Prenatal Massage

...love your baby

www.utahprenatalmassage.com

Name: _____ Referred by: _____

Address: _____ Zip code: _____ Phone #: _____

E-mail Address: _____

Today's Date: _____ Birth date: _____ Occupation: _____

General Information:

It is our intention to provide you a safe and nurturing experience during or after your pregnancy. We need to be aware of conditions you have experienced in order to modify your session(s) in the best interest of you and your baby. **Please carefully review and complete the information on the intake and release forms with your healthcare provider and obtain the necessary signatures before arriving at your first massage appointment.**

Massage therapy during pregnancy or postpartum is not intended to replace prenatal and postpartum care. Used as a form of adjunctive healthcare, potential benefits include:

- Reduces stress and promotes relaxation and normal blood pressure
- Relieves muscle spasms, cramps, and myofascial pain, especially in the back, hips and legs.
- Increases blood and lymph circulation and supports the physiological process of pregnancy.
- Reduces stress on weight-bearing joints and eases musculoskeletal strain and pain.
- Provides emotional support and physical nurturance
- Enhances a woman's kinesthetic awareness and her ability to relax deeply which may be helpful during delivery.
- Offers labor supportive techniques that may increase comfort during labor.
- Promotes shorter, less painful labors and reduction of complications, including prematurity, and interventions.
- Assists postpartum restoration of abdomen and weight-bearing muscles and joints.
- Provides new mothers postpartum support with the physical and emotional aspects of infant care.
- Promotes healing, including post-cesarean scars.

Prenatal Intake and Health History

1. What discomforts, pain, or other needs are you hoping to have addressed through massage therapy?
2. In what week of your pregnancy are you? What is your estimated due date?
3. Who is your birth partner?
4. Please describe your birth vision:
5. Do you have any medical conditions or current surgeries / procedures unrelated to pregnancy that I should be aware of?
6. Are you currently experiencing any infection or disorder?
7. Please list any medications you may be taking:
8. Is there other relevant information about this pregnancy, a previous pregnancy, or about you that I should know?

Please indicate any of the high-risk factors, complications, or conditions listed below, and discuss your condition with your maternity healthcare provider. Postpartum massage can begin 24 hours after delivery. If there were complications or a cesarean delivery, you must have written release from you healthcare provider if you wish to receive massage in the first six weeks postpartum.

High risk factors (please check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Pre-pregnancy diabetes | <input type="checkbox"/> Genetic disorders / DES exposure |
| <input type="checkbox"/> Uterine abnormalities | <input type="checkbox"/> Multiple pregnancy |
| <input type="checkbox"/> Hypertension / high blood pressure | <input type="checkbox"/> Mother's age under 20 / 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:
(pre-eclampsia / eclampsia / toxemia) |
| <input type="checkbox"/> Placental dysfunctions | <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"/> Infection |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Other _____ |

Contraindicated for affected areas only:

- | | |
|---|--|
| <input type="checkbox"/> Severe varicose veins | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Skin irritation and / or discharge | <input type="checkbox"/> Fracture, bleeding, burns or other injury |

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To: Client

Re: Release

I verify that I have discussed with my maternity healthcare provider the health concerns that I have about massage therapy and that (check one):

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

I have noted all prenatal complications, risks, or conditions I am / have experienced AND I have obtained my maternity healthcare provider's release.

It has been made very clear to me that massage therapy is not a substitute for medical examination and/or diagnosis and that it is recommended that I see a physician and my maternity healthcare provider for any physical ailment and concerns with my pregnancy.

I, the undersigned, am aware that my therapist is associated with Utah Prenatal Massage. I release Utah Prenatal Massage and my therapist from any liability associated with my or my child's massage therapy sessions. Because my therapist must be made aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health and any changes in my pregnancy.

Print Name: _____

Signature: _____ Date: _____

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To: Maternity Healthcare Providers

Re: Release for Therapeutic Massage During Pregnancy/Postpartum

Your Patient, _____, has requested therapeutic massage by a certified Pre- and Perinatal Massage therapist (certification requires completion of a comprehensive hands on training program as well as passing both a written and practical exam).

It is our policy to work on her in consultation with her maternity healthcare provider. Please review this request with her. In addition, if her pregnancy is high-risk, or she has experienced any complications or contraindicated conditions, we require a written release from her healthcare provider stating any specific limitations or precautions that you feel to be appropriate.

Please verify your clearance of this request by your signature below. This verification can be modified or withdrawn at any time should your patient's health status change. Thank you for your time and assistance.

Patient's pregnancy is (please circle one): normal progression high-risk

Specific limitations or precautions:

You may contact me directly for clarification or concerns regarding this patient. Yes / No

Signature: _____ MD CNM DEM Other Date: _____

Printed Name: _____ Office Phone: _____