POSTPARTUM MASSAGE INTAKE FORM

Name_____**Date**_____

Address_____

Phone_____ **Can you receive text on this phone?**

EMAIL _____ **Date of Birth** _____

I would like to receive occasional emails about massage specials? _____

How did you hear about me? _____

Emergency Phone Contact: Name _____ **Phone** _____

Prenatal Care Provider: _____

I birthed my last baby on this date: _____

This was my ____(1st, 2nd, 3rd, etc) pregnancy, and_____(1st, 2nd, 3rd) birth

So that I may provide optimum care, please inform me each visit of changes in your condition.

Please check √ current conditions/complaints. Mark with + if you had in the past.

___Anemia
___Allergies _____
___Back Surgery or injury
___*Spinal Disc Issues
___Separated Pubic Symphysis
___Separated Abdominal Muscles
___Sciatica
___Abdominal/uterine cramping
___Bleeding (uterine)
___Dizziness
___*Visual disturbances
___*Preeclampsia
___Chronic Hypertension
___Gestational hypertension
___*Blood Clot or Blood clotting disorders
___Varicose veins
___Cancer
___Cesarean birth
___Episiotomy/Laceration and repair
___Lactation/Breast feeding difficulties
___Fibromyalgia
___Leg cramps
___Low back pain
___ Skin disorders/Athletes Foot
___Carpal Tunnel Syndrome
___IVF/fertility treatment during pregnancy
___IUD or other internal birth control in place
___Nausea
___Heartburn
___Diabetes
___Bladder or kidney infection
___Insomnia
___Headaches
___Seizures
___Recent Airplane Travel
___Incontinence of urine or feces (circle)
___Pelvic Pain
___Anything you consider as Birth Trauma
___Tubal Ligation
___Breast discomfort
___Other physical condition/discomfort that you wish to resolve or that should be addressed:

_____

What is your goal for treatment today? _____

Type of massage I prefer (Check): Swedish ___ / Cranial Sacral Therapy ___ /Deep Pressure___ / Acupressure___ / Myofascial Release___ / Reflexology___ / Rolfing

OPTIONAL TREATMENTS or INFORMATION:

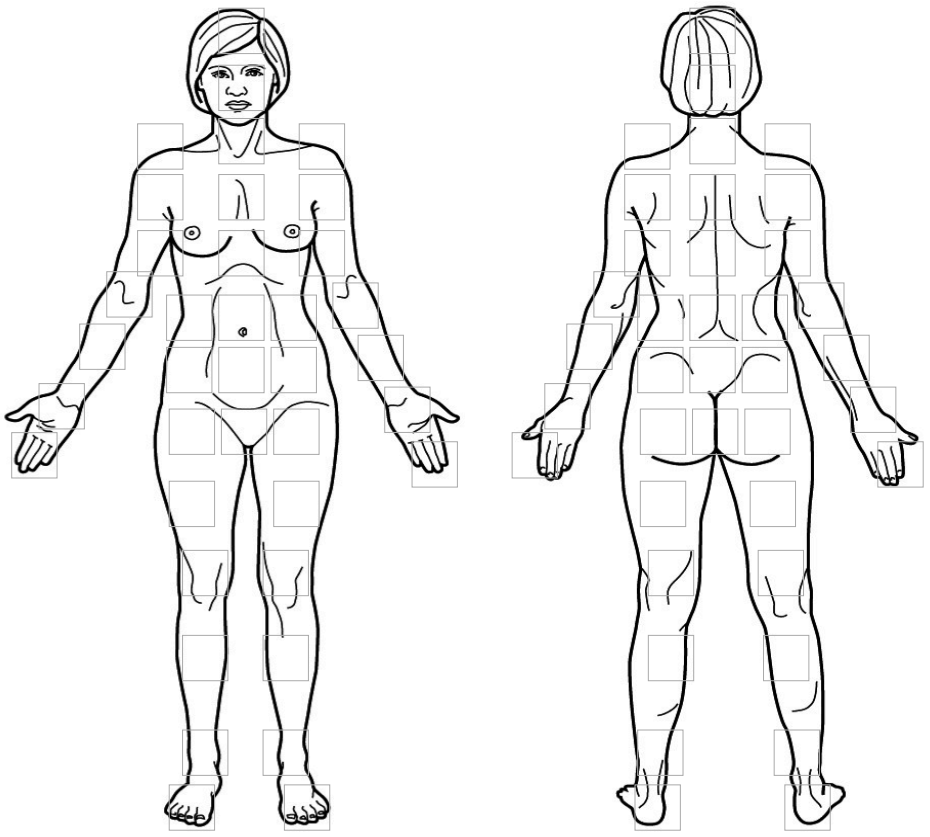
Check if you would like to know about any of the following:

___I would like information about therapeutic Holistic Pelvic Care™ that may help with pelvic pain, incontinence, birth trauma, prolapse, and more.

____I am interested in therapeutic *self*-breast massage or *professional* bodywork to support breast discomforts and lactation.

____Please check me for a Diastasis Recti (separation of the abdominal muscles) that can occur during pregnancy and cause back pain and lack of pelvic, back, & abdominal support.

____Please tell me more about Yoni Steam Bath and Closing the Bones.



(a) Anterior view **(b) Posterior view**

Circle areas of primary discomfort.

I understand that I must give 24 hours notice for cancellation of scheduled session or will be responsible to pay for that session. Thank you!

SIGNED_____**Date:** _____