In Balance
Healing Massage & Bodywork Center

Pregnancy Questionnaire
Medical History Form
PLEASE PRINT

Client Information

Name:	Marital Status:	Date of Birth:
Address:	Town / Zip:	
Phone (Home/Cell):	Email:	
How did you hear about us?	Is this your first massage?	
Is there a specific reason you are seeking massage at this time?		
Have you received any alternative treatments? If so what are they?		

Medical History

What are your exercise habits?	How much water do you drink?	
What are your dietary habits?	Coffee?	Alcohol?
Primary Physician:	Date of last physical:	
List all Diagnoses from your Primary Care Physician:		
Medications / Natural Supplements:		

Circle any of the following conditions or issues that you have had prior to pregnancy from the list below:

Allergies
Arthritis
Anemia
Anxiety / Depression
Asthma
Autoimmune
Back / Neck
Bladder
Bleeding / Bruising
Broken Bones
Blood Pressure
Blood Clots / Phlebitis
Bowel / Digestion
Bursitis / Tendonitis
Cancer
Cataracts
Chest / Lung
Chronic Tension
Circulation
Clenching / Grinding
Cold Sweats
Constipation / Diarrhea
Contact Lenses / Glasses
Concussions / Contusions
Dental
Diabetes
Dialysis
Dizziness / Fainting
Eye
Excessive Worry / Grief
Fatigue
Female Organ
Fibromyalgia
Fractures / Dislocations
Headaches / Migraines
Heart / Cardiac
Hepatitis
Hernia
Inflammation
Internal Hardware / Pacemaker
Joint
Kidney / Gallbladder
Lyme
Mental / Emotional
Limited Range of Motion
Lymphatic Disorder
Mold Exposure
Mood Disorders
Neurological
Neuropathy
Osteoporosis
Pinched Nerve
Pregnancy
Prosthetic Implant
Psychiatric
Respiratory
Restless Leg Syndrome
Scars
Sciatica
Scoliosis
Seizures / Epilepsy
Sinus
Skin Condition
Sleeping
Smoke / Drink
Spasms
Sprain / Muscle Strain
Stress
Stroke / TIA
Substance Abuse
Surgeries
Swelling
Thyroid
TMJ / Jaw
Ulcers
Weakness / Numbness
Varicose Veins
Vertebral / Disc

Describe the circled above in detail. Make sure to include ANY accidents, dental procedures, falls, injuries, long-standing health matters, organ issues, syndromes, or anything pertinent to your health status from in utero to today.

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Prenatal History

How many weeks pregnant are you?	Due Date (M/D/YYYY):
Was this pregnancy planned?	Did you have trouble conceiving?
If no, is this your first pregnancy?	How many children do you have?
OB/DO/Midwife of this pregnancy:	
Are you utilizing the services of a Doula for this pregnancy?	If yes, who is your doula?
Do you have any questions/concerns for the massage therapist?	
Have there been complications during this pregnancy or previous ones?	

Circle any of the following conditions or issues you have experienced during this pregnancy, prior, or postpartum:

Abdominal Pain	Falls / Slips	Mid / Low Back Pain	Pregnancy Trauma
Bed Rest	Gestational Diabetes	Morning Sickness	Sleep Issues
Bleeding	General Discomfort	Neck / Shoulder Pain	Swelling
Blood Clots	Headaches / Migraines	Numbness / Tingling	Tingling
C-Section	High Blood Pressure	Pelvic Floor Prolapse	
Depression / Anxiety	Indigestion / Heartburn	Pelvic Pain	
Difficulty Breathing	Joint Pain	Pregnancy Loss	Other: _____

Previous Birth History

Place of your child's birth: (Hospital / Birthing Center / Home / Other)

Delivering Practitioner: (OB/Gyn / Nurse Midwife / Certified Practicing Midwife / Lay Midwife

Position of Delivery: (Lithotomy / On Your Side / Kneeling / Squatting / Birthing Chair / Birthing Tub / Caesarian Section)

If Caesarian Section, please explain why:

Was labor induced?

- If YES, were contractions stimulated prior to the natural onset of labor?
- If YES, were contractions stimulated after labor had started?
- If YES, specify type: IV Pitocin / Prostaglandin Gel / Unknown

Were your membranes stripped or ruptured?

Did you utilize any pain medications or anesthesia?

- If YES, please specify type used:
- How many centimeters were you dilated when it was administered?
- How did it effect labor?

Did you experience Back Pain during labor?

Baby presentation at time of delivery: (Normal / Posterior / Brow / Facial / Breech)

- If Breech, specify type: (Footling / Frank / Complete / Kneeling)

Did you care provider assist the delivery with his or her hands?

- If YES, was there any turning or pulling applied to the baby's neck?

Was there any visible injury to the baby?

- If YES, where and how was the baby injured?

Were operative devices used to facilitate the birth?

- If YES, which type? (Forceps / Vacuum Extraction / Other)
- If YES, was there any visible signs of injury to the baby?
- If YES, where was the injury sustained?

Was there a birthing coach pregnant? (Husband, Doula, Friend, Other)

At what week of pregnancy was the baby born?

Did you have any complications during any of your previous pregnancies?

- If YES, please explain:
- If miscarriages, please list dates and weeks of gestation:

Did you experience Post Partum Depression after the birth?

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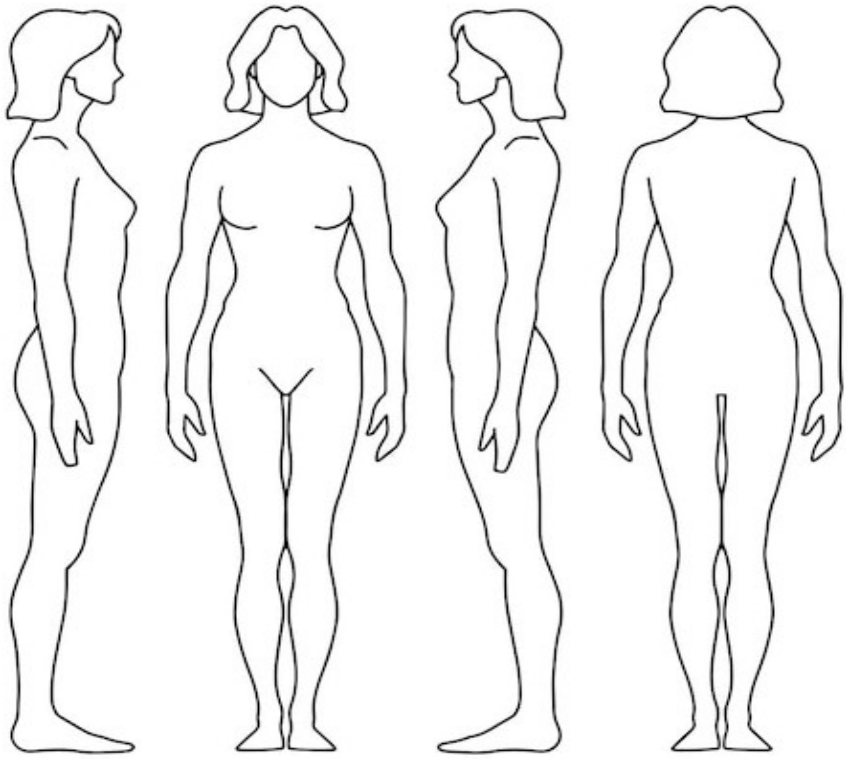
Please indicate on the drawings below where your pain is. Use the key to identify the type of pain you are feeling in that area.



RIGHT SIDE FRONT LEFT SIDE BACK

KEY

A - Ache
B - Burning
I - Inflammation
N - Numbness
P - Pins / Needles
R - Radiating Pain
S - Spasm
T - Tension
O - Other

Client Agreement

I understand that massage therapy is not a substitute for medical diagnosis or treatment, and that it is recommended I concurrently work with my Primary Caregiver for any condition I may have. I am also aware that the massage therapist does not diagnose illness or disease and does not prescribe medications. I have informed the massage therapist of all known physical / medical conditions, and I will keep the massage therapist updated on any changes in my health status and / or medications.

If you must reschedule a 24 hour notice is appreciated.
Same day cancellations will be billed at half price. No shows will be billed at the full price.
Emergencies are understood.

My signature hereby verifies the above information is complete and true, and that I agree to the above terms.

Print Name: _____ Date: _____

Sign Name: _____

Notes for your Practitioner:

Continued Client Notes for: