Heart Stone Therapeutic Massage Prenatal Intake Form

Name:_____ Today's date: _____

Birthdate:_____ Expected due date: _____

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

2. In what week of your pregnancy are you? _____

3. Are you regularly seeing a physician, nurse - midwife, or midwife? Please provide name and phone number. Name: _____ Phone number:_____

4. Have you had any complications or problems with this pregnancy? Circle those that apply: bleeding, cramping, amniotic fluid leakage; swelling; high blood pressure, rapid weight gain, protein in urine; vision disturbances; severe nausea, vomiting, or headache; abnormal fetal heartbeat, or movement; high blood sugar; other:_____
_____

5. Is your pregnancy considered to be high risk (due to diabetes, hypertension, multiple pregnancy, previous complicated pregnancy, genetic problems, age under 20 or over 35 years)?
_____

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

Please Note: In addition to prenatal intake form please fill out standard Heart Stone TM Health History Form.