

Prenatal Massage Release Form

Name: _____ Date of Birth: ____/____/____

How far along are you in your pregnancy? _____ Due Date: ____/____/____

Potential benefits of prenatal massage

- Promotes relaxation, reducing stress & anxiety
- Relieves muscle aches, spasms, cramps & myofascial pain
- Enhances body awareness for better posture
- Relieves headaches, sciatica, soreness in feet & pain in the back, neck, hips, legs & joints
- Improves blood and lymph circulation, increasing cellular nutrition
- Reduces strain on weight-bearing joints and musculo-fascial structures
- Reduces swelling and edema
- Improves breathing patterns, reduces fatigue & promotes deeper sleep for longer periods
- Provides emotional support and physical nurturance
- Improves outcome of labor and newborn health
- Postpartum restoration of abdomen and weight bearing muscles and joints

Have you experienced any of these conditions during your current pregnancy?

<input type="checkbox"/> Anemia	<input type="checkbox"/> Edema/swelling	<input type="checkbox"/> Hypo/Hyperglycemia	<input type="checkbox"/> Abdominal cramping
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Pre-term labor	<input type="checkbox"/> Breathing difficulties	<input type="checkbox"/> Blood Clot or Phlebitis
<input type="checkbox"/> Nausea	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pre-eclampsia	<input type="checkbox"/> Gestational Diabetes
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Leg cramps	<input type="checkbox"/> Round ligament pain	<input type="checkbox"/> Placental dysfunction
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Uterine abnormalities	<input type="checkbox"/> Carpal Tunnel Syndrome

Other conditions/problems in current or past pregnancy: _____

Are you currently experiencing a high risk pregnancy? _____

*A physician's written clearance is required if you are experiencing a high risk pregnancy

Have you had a prenatal/pregnancy massage before? _____ If so when? _____

Any concerns you would like to discuss? _____

Areas of stress or pain? _____

I, _____ hereby state that I have completed this health form to the best of my knowledge. If any complications or changes arise, I will discuss these with my massage therapist. I will immediately let my therapist know of any pain or discomfort I experience during the session so that pressure can be adjusted to my level of comfort. I understand that massage does not take the place of a physician's care. Any personal or medical information obtained during a massage session is confidential and is only used to provide appropriate treatment. I hold harmless, defend, release and discharge the massage therapist from any and all claims, liabilities, damages and actions without limitation from massage therapy received.

Signature _____ Date: _____