



Pregnancy Confidential Intake Form

Pregnant Person's Name: _____

Estimated Due Date _____

Address _____ Town _____

State _____ Zip _____ Date of Birth _____ Age _____

Partner's Name: _____

Home Phones _____

Work Phones _____

Cells _____

Emails _____

Previous birth experience: _____

Childbirth class? _____

Marital/Relationship status _____ Referred by _____

Delivering at Home? Hospital? _____

Midwifery/obstetric careprovider _____

Who else will be attending your birth?

Do you know the sex of your baby? Have you named your baby yet?

Was your baby conceived with fertility assistance?

Are you having any challenges with this pregnancy?

Have you considered using a doula? If so, who have you hired?

Is there anything else you would like me to know?

Client Confidentiality and Release Form

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations. The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client *before* taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

I, (name) _____

give my permission, for my practitioner to take notes including health history/ medical and /or personal information I choose to disclose to him/her.

Client Signature: _____ Date: _____

Practitioner signature _____ Date: _____

Client Name:

Pregnancy Comfort

What pain or discomfort have you had during this pregnancy?

When did your first notice it? _____ What brought it on? _____

Describe any stressors occurring at the time _____

What activities provide relief? _____ what makes it worse? _____

Is this condition getting worse? _____ interfere with work _____ sleep _____ recreation _____

Have you had massage/bodywork before? _____ What type? _____

Medical History

Gender: Sex assigned at birth _____ Gender currently identifying as _____

Are you currently under the care of another health care provider(s)? _____ Reason (s) _____

Name(s) of Practitioner _____ Address: _____

Phone _____ email _____

Current Medications and /orSupplements/Remedies: _____

Allergies: specify allergen and reaction: _____

Surgical History (year and type) and/or Recent Procedures: _____

Hospitalizations: _____

Accidents or Traumas _____

Falls/Injuries to Sacrum/head/tailbone (describe) _____

Other:

Please review and check the following:

	Past	Present		Past	Present
Headaches Type:			Numbness in feet or legs when sta		
Asthma			Sore heels when walking		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Low Back Pain			Muscular Tension: Location:		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Herniated/Bulging Discs		
Painful/Swollen Joints			Artificial/Missing limbs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Cancer (past or current) Type		

Family History

	Still Living?	Cause and Age of Death	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Gastrointestinal Health History

Describe your typical:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____ Water Intake(glasses/day) _____ Caffeine _____

What is the worst item in your diet _____ What foods are your weakness _____

Are you subject to binge eating? _____ What foods _____

Do you experience bloating/gas/burps after eating? _____ What foods trigger this? _____

Food Allergies? _____ Describe _____

How often are your bowel movements? _____ Do your stools: sink _____ float _____

Constipation? _____ Blood in stool? _____ Mucus in stool? _____ Pain when stooling? _____

Diarrhea? _____ Other? _____

Lifestyle, Emotional & Spiritual

What is your opinion of yourself? _____

Describe the most positive emotion you experience _____

When and Where do you experience this emotion? _____

Describe the most negative emotion you experience _____

When and Where do you experience this emotion? _____

Describe your Spiritual and/or Religious practice: _____

On a scale of 1 – 10 (1 being the lesser, 10 the greater) Please rate yourself in each of these qualities:

Faith _____ Hope _____ Charity _____ Generosity _____ Sense of Humor _____ Fear _____ Grief _____ Sense of Fun _____

What hobbies/ activities provide you with pleasure and accomplishment _____

Describe your exercise routine (type, frequency) _____

What changes would you like to achieve in 6 months: _____

One Year: _____

Do you use Tobacco? _____ Quantity _____ /ppd Alcohol? _____ Quantity _____ ounces/ day

Marijuana? _____ Quantity _____ Other: _____ Have you been under treatment for substance use?

Gynecological Health History

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method
 Fertility Awareness Other: _____ Length of time using method _____ Last Pap smear _____ Results _____
 Are now or in the past experiencing Fertility Challenges? Yes ___ No ___ Describe your treatment : _____
 (IUI, IVF, etc) _____

Menstrual History Review and check as indicated:

Age of Menses: _____ What was this like for you? _____

Last Menstrual Period: _____ Length of Menses _____

Are you trying to Conceive? Yes ___ No ___ Are you Pregnant? Yes ___ No ___ Unsure ___

Painful Periods	Past	Present	Irregular cycles Early Late	Past	Present
	Heaviness in Pelvis prior to menses				Dark Thick Blood at: Beginning End Both
Excessive Bleeding Pads per Hour			Headache or Migraine with menses		
Dizziness			Bloating		
Water Retention			Ovulation: Painful Failure to		
Endometriosis Location (if known)			Fibroids Location (if known)		
Uterine or Cervical Polyps			Uterine Infection(s)		
Vaginal Infection(s)			Cysts Location:		
Bladder Infection(s)			Urinary Incontinence		
Painful Intercourse			Vaginal Dryness		
Episodes of Amenorrhea How long?					

Rate your interest in Sex: High _____ Moderate _____ Low _____ None _____

Do you have or ever had difficulty experiencing orgasms _____

Have you experienced trauma? Yes ___ No ___ Describe _____

Did you undergo counseling for this _____

What was this like for you _____

Pregnancy History

Number of Pregnancies: _____ Dates _____ Miscarriage(s) _____ Dates _____ Termination(s) _____ Dates: _____

Number of Births: _____ Dates: _____

Complications for any of the above, describe: _____

Premature Births? _____ Spotting During Pregnancy? _____ Weak Newborns? _____ Incompetent Cervix? _____

Describe your experience with:

Pregnancy: _____

Labor: _____

Birthing _____

Post Partum: _____

Maternal Family History of (please circle) Infertility Fibroids Endometriosis-----PMS Menopause

Cancer(type) _____ Menstrual Problems _____ Other _____

Medications your mother took when she was pregnant with you (if any) _____

Your Birth Trauma (if known) _____

Menopause

Age symptoms began: _____ Are they getting worse _____ better _____ same _____

Are you on/ or ever been on hormone replacement therapy? _____ if so, how long _____

Name and dose _____

Reason for stopping _____

Age of Mother at menopause: _____ Concerns/Experience _____

Check the following symptoms that apply to you:

Hot flashes	Insomnia	Fatigue	Memory Loss	Mood Swings
Vaginal Discharge	Dry Vagina	Depression	Anxiety	Irritability
Spotting	Flooding	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Additional Information you feel important your practitioner should know that is not mentioned here:

Urological Health History

Please check the symptoms below that apply

Painful Urination	Past	Present	Urinary Retention	Past	Present
Urinary Incontinence or Dribbling			Difficult starting or holding urine stream		
Weak or Interrupted Urine flow			Blood or pus in urine		
Pain or Burning with Urination			Pelvic pressure		
Nocturnal Urination How many times?			Insatiable sex drive		
Pain in lower back, esp After intercourse			Pain or Discomfort Between scrotum and Testicles		
Pain or Discomfort in: Penis Testicles Rectum			Pain or Discomfort in Inner thighs: Left Right Both		
Frequent Bladder or Kidney Infections When?			Erection: Difficulty in Obtaining Maintaining Painful ejaculation		

Results of PSA (prostate specific antigen) Test if known _____ Date done _____

Results of Sperm count (if applicable and known) _____ Date done _____

Family History of Prostate Disease: Yes ___ No ___ Type _____ Relationship _____

Family History of Cancer Yes ___ No ___ Type _____ Relationship _____

Sexually transmitted disease Yes ___ No ___ Type if Known _____

Rate your interest in Sex: High _____ Moderate _____ Low _____ None _____

Do you have a history of trauma: describe _____

Did you undergo counseling for this _____

What was this like for you _____

Additional Comments:



Consent for Massage Therapy

New York State Consumer Information: Who are massage therapists?

Massage therapists are licensed health professionals who apply a variety of scientifically developed massage techniques to the soft tissue of the body to improve muscle tone and circulation. Massage therapists work to enhance well-being, reduce the physical and mental effects of stress and tension, prevent disease, and restore health.

New York State Statute: § 7801. Definition of practice of massage therapy

The practice of the profession of massage therapy is defined as engaging in applying a scientific system of activity to the muscular structure of the human body by means of stroking, kneading, tapping and vibrating with the hands or vibrators for the purpose of improving muscle tone and circulation.

Massage Therapy Consent:

The client understands that . . .

- The relationship between the client and the massage therapist is a confidential one and that all information provided to the therapist is to be kept confidential.
- The massage therapist will respect the patient's/client's right to an informed and voluntary consent for the release of patient/client information.
- The massage offered is solely for therapeutic reasons and both the client and the massage therapist have the right to be free from any unwanted, harmful and/or offensive (physical or other) behavior.
- The client's body will be properly draped at all times for comfort, security and warmth. Only the body areas receiving immediate therapy will be undraped.
- The massage therapist will respect the patient's/client's right to refuse, modify or terminate treatment, regardless of prior consent for such treatment.
- The massage therapist will not cause the patient/client more pain than the patient/client is willing to accept, nor will they exert any psychological pressure to induce the patient/client to accept a level of pain higher than the patient/client has expressly agreed to experience.
- It may be necessary to obtain permission from the client's healthcare provider (primary care or other physician) to receive or continue therapy.
- The client will inform the massage therapist of any discomfort during the massage session, so that the application of pressure or strokes may be adjusted to my level of comfort.
- The client understands that massage is a touch modality and may trigger strong emotional responses in the client. The client will immediately inform the massage therapist of any emotional discomfort.
- Therapeutic massage is an ancillary treatment and is not intended as a primary medical treatment.
- The massage therapist does not diagnose conditions and I may be asked by my therapist to contact my primary care physician to receive a proper diagnosis.
- Should the client have to cancel an appointment for any reason, I agree to give the massage therapist notification at least 24 hours in advance of that appointment.
- The client freely gives permission to receive massage therapy treatment.

Client (print please): _____ Date: _____

Client (or guardian): _____ (signature)

Massage therapist: _____ Date: _____

Consent Addendums:

Application of therapeutic massage techniques may be made to all areas of the body with the exception of the genital area. It is important to note that there are other areas of the body that, though they can be legitimately accessed for therapeutic reasons, may be sensitive in some manner for the client. The following consent waivers are for those regions of the body that can be, but are not considered part of a standard full-body massage therapy. The following waivers are only valid in conjunction with a properly signed "Consent for Therapy" as found on the reverse side of this document.

Consent for massage therapy to the gluteal and deep hip rotator muscle (buttock) area

This area includes the soft tissue from the gluteal cleft, moving lateral to the tensor fascia lata, superior margin is the iliac crest and the inferior margin is to the ischial tuberosity. Draping is performed to expose this area yet leave the genital area covered.

- The massage therapist has discussed with me issues involving massage therapy for the buttock and hip area to my satisfaction.
- I freely give my permission to receive massage therapy treatment to the buttock and hip area.

Client (or guardian): _____ Date: _____

Therapist: _____ Date: _____

Consent for massage therapy to the abdominal region

This area includes the soft tissue superior to an imaginary line drawn from the left AIIIS to right AIIIS of the client and inferior to the tissue of the female breasts and/or the fifth (5) rib. This area also includes anterior access to the psoas and iliacus muscles within the pelvic girdle.

- The massage therapist has discussed with me issues involving massage therapy for the abdominal region to my satisfaction.
- I freely give my permission to receive abdominal massage therapy.

Client (or guardian): _____ Date: _____

Therapist: _____ Date: _____

Consent for breast massage therapy (females only)

This area includes the soft tissue of the breast including extensions of breast tissue to the axilla (arm pit region), lower edge of the clavicle, sternal mid-line and the anterior edge of the latissimus dorsi. Breast massage does not include touching the nipple of the breast.

Due to the sensitive nature of breast massage, the therapist and the client each retain the right to immediately modify or terminate treatment for any reason.

- The massage therapist has provided me with written materials regarding the health benefits of therapeutic breast massage.
- The massage therapist has discussed with me issues involving breast massage therapy to my satisfaction.
- I freely give my permission to receive breast massage therapy.

Client (or guardian): _____ Date: _____

Therapist: _____ Date: _____