SMART
integrative massage group

94 Valley Road # 2A, Montclair, NJ 07042 223 Route 18 South # 205, East Brunswick, NJ 08816
973-744-1576 smartmassagegroup@gmail.com

PRENATAL MASSAGE INFORMATION FORM

Name _____ Date of Birth_____

Address _____ City _____ State _____ Zip _____

Phone: (_____)_____E-mail: _____

Referred by: _____Phone (_____) _____

In case of emergency: _____ Phone (_____) _____

Physician_____ Phone (_____) _____

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

2) In what week of your pregnancy are you?

3) Are you regularly seeing a physician, nurse-midwife, or midwife? Who?

4) Have you had any complications or problems with this pregnancy? Circle those applicable: bleeding, cramping, amniotic fluid leakage, water retention, high blood pressure, rapid weight gain, protein in the urine, vision disturbances, severe nausea, vomiting or headaches, abnormal fetal growth, heartbeat or movements, high blood sugar, other:

5) Do you have any medical conditions? Circle those applicable: diabetes; heart, liver, kidney, or lung disorders; uterine abnormality; connective tissue or collagen diseases; other:

6) Are you currently experiencing an infection or disorder? Circle those applicable: COVID -19, common cold, bladder infection, skin irritation, varicose veins, others:

7) Is your pregnancy considered to be high risk? (Diabetes, hypertension, multiples pregnancy, previous complicated pregnancy, asthma, Rh or genetic problems, under 20 or over 35 years old, fetal genetic disorders, or exposure to hazardous materials):

8) Is there other relevant information about this pregnancy or you that I should know?

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____