

PREGNANCY

1. In what week of pregnancy are you? _____
2. Check any discomfort or pain you are experiencing:
- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> insomnia | <input type="checkbox"/> morning sickness |
| <input type="checkbox"/> tender breasts | <input type="checkbox"/> other | |
3. Are you regularly seeing a physician, nurse-midwife or midwife?
Name: _____
4. For all of the complications that apply to this pregnancy, please insert **P** for past, and **C** for current:
- | | | |
|---|---|---|
| <input type="checkbox"/> abnormal fetal growth | <input type="checkbox"/> abnormal fetal heartbeat | <input type="checkbox"/> abnormal fetal movements |
| <input type="checkbox"/> amniotic fluid leakage | <input type="checkbox"/> bleeding | <input type="checkbox"/> cramping |
| <input type="checkbox"/> headaches | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> high blood sugar |
| <input type="checkbox"/> protein in urine | <input type="checkbox"/> rapid weight gain | <input type="checkbox"/> severe nausea |
| <input type="checkbox"/> vision disturbances | <input type="checkbox"/> vomiting | <input type="checkbox"/> water retention |
| <input type="checkbox"/> other | | |
5. Check any other medical conditions that apply:
- | | | |
|--|---------------------------------|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> asthma | <input type="checkbox"/> collagen disorder |
| <input type="checkbox"/> convulsive disorder | <input type="checkbox"/> other | |
6. Check any infection or disorder you are currently experiencing:
- | | | |
|---|--|--|
| <input type="checkbox"/> cold | <input type="checkbox"/> bladder infection | <input type="checkbox"/> skin irritation |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> cystitis | <input type="checkbox"/> yeast infection |
| <input type="checkbox"/> other | | |
7. Check any applicable high risk conditions you may have:
- | | | |
|---|---|---|
| <input type="checkbox"/> cardiac disorder | <input type="checkbox"/> connective tissue disorder | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> exposure to drugs | <input type="checkbox"/> exposure to hazardous material | <input type="checkbox"/> fetal genetic disorder |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> liver disorder | <input type="checkbox"/> multiple pregnancy |
| <input type="checkbox"/> previous miscarriages (2+) | <input type="checkbox"/> previous complicated pregnancy | <input type="checkbox"/> renal disorder |
| <input type="checkbox"/> Rh or genetic problems | | <input type="checkbox"/> uterine abnormality |
| <input type="checkbox"/> other | <input type="checkbox"/> under 20 or over 35 years old | |
8. Is there any other relevant information about this pregnancy or about you that I should know? Yes No
- _____

If you've checked any conditions in #4, 5, or 7, your doctor's written permission for Massage may be required.

Client Signature

Date