actaea**works, ltd.**
salon spa boutique

Pre-Natal Massage Intake Form

Name____ Age__________

Have you had massage before? __________ Last treatment ______________________

Medical Concerns? ____

Allergies? ____

Recent injuries or surgeries? ____

Medications? ____

What exercise activities do you participate in? ______________________________

What areas would you like your massage therapist to focus on? ______________________

Please check any of the following that pertain to you:

- ❏ Have you ever experienced preterm labor, or miscarriage?
- ❏ Are you experiencing any of the following: Placenta previa, Placenta abrupto, gestational diabetes, renal disease, cardiovascular disease, systemic lupus or other autoimmune factors and/or preclampsia/eclampsia?
- ❏ Have you had morning sickness, vomiting, diarrhea, or fever?
- ❏ Have you noticed reduction in fetal movement during the previous 24 hours?
- ❏ Have you had excessive swelling in your arms, legs, hands or feet?
- ❏ Do you have poor circulation in your legs? (DVT Deep Vein Thrombosis)
- ❏ Have you been or are you currently, inactive, or placed on bed rest?
- ❏ Have you experienced any abnormal bleeding or abnormal discharge in the last 24 hours?

By answering these questions you are stating that you are experiencing a normal and healthy pregnancy, are past your first trimester and have asked to receive this massage.

Signature____ Date________________

www.actaea.com

reservations tel. 414.962.9889 or email reservations@actaea.com

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