Feel Better Remedial Massage

PREGNANCY FORM

Personal information

First name Portia Last name Stephens

Mobile number 043 77 747 560 Email stephensportia@gmail.com

Date of birth 20 / 10 / 1991

Address 152 Brockwater road

Postcode 4122 Occupation engineer

Emergency contact

First name Alistair Last name Francis

Mobile number 04 20 219 559 Relationship partner

Health History

If you have a history of any of the following conditions, please check below.

☐ Heart Conditions ☐ Diabetes ☐ Asthma ☐ Headaches/Migraines ☐ Dizziness

☒ Pregnant ☐ High Blood Pressure ☐ Allergies ☐ Cancer ☐ Joint Replacement

☐ Loss of Balance ☐ Numbness ☐ Recent Accident/Injury ☐ Shingles

☐ Sleep Disorders ☐ Blood Clots ☐ Depression/Anxiety ☐ Infectious Conditions

☐ Kidney Conditions ☐ Neck/Spinal Injury ☐ Skin Disorders ☐ Varicose Veins

Health History Details

If you checked to any of the above questions, please provide further information here.

Surgeries

Current complaint

How Many Weeks Are You? 22 DUE DATE 28-July-2025

What is the reason for your visit? back pain

When did the problem begin? 5 years

Have you consulted any other health professionals about this problem? If so, please provide details

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PREGNANCY WELL BEING

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

☐ Vaginal Bleeding And Or Abnormal Discharge ☐ Fever Toxaemia/Preeclampsia

☐ Excessive Swelling Of Hands, Legs And Or Face ☐ Varicose Veins

☐ Decreased Fetal Movement In The Past 24 Hours ☐ Diarrhoea/ Vomiting

☐ Diabetes ☐ Pre-Term Labour ☐ Abdominal Pain Or Unusual Pain Anywhere Else In The Body

Other - please specify

* If you have checked any of the above, your therapist may need approval of your physician to treat you.

HAVE YOU HAD ANY COMPLICATIONS OR ABNORMALITIES?

If yes, please describe:

Treatment consent

I have to the best of my knowledge, provided all relevant information about my health and medical history and I give my full consent to treatment. I intend this consent to apply to all future treatments and I understand that I must update my service provider with any changes that may occur in my medical history. I understand that a 50% cancellation fee may apply if I do not provide at least 24 hours notice.

☒ I consent to treatment

☒ I consent to receiving SMS and/or email for booking confirmation

Full Name Portia Stephens

Signature [signature] Date 4/4/25