

Feel Better Remedial Massage

PREGNANCY FORM

Personal information

First name Monique Last name Baillie
Mobile number 0424 196 975 Email monique.baillie@gmail.com
Date of birth 19/02/90
Address 51 Lynmouth St, Upper Mt Gravatt
Postcode 4122 Occupation Advertising

Emergency contact

First name Leithen Last name Baillie
Mobile number 0431 556 786 Relationship Husband

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? 29 DUE DATE 6/07/25
What is the reason for your visit? Relax + sore muscles
When did the problem begin? General pregnancy

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

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

Monique Brille

Signature

[Signature]

Date

23/04/25