Feel Better Remedial Massage

PREGNANCY FORM

Personal information

First name RACHEL Last name NORRIS

Mobile number 0434 281 724 Email rachiee.norris@gmail.com

Date of birth 06/02/1989

Address 17/16 VIOLET CLOSE SMP

Postcode 4113 Occupation ADMIN.

Emergency contact

First name WAYNE Last name NORRIS

Mobile number 0449 823 652 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.

10 WEEKS PREGNANT.

Surgeries C-SECTION

Current complaint

How Many Weeks Are You? 10 WEEKS DUE DATE 1ST FEB 2026

What is the reason for your visit? tightness. no specific issues.

When did the problem begin?

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? NO.

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 RACHEL NORRIS

Signature _____ Date 7/07/2025