CONFIDENTIAL ONGOING PREGNANCY MASSAGE HEALTH HISTORY FORM

Please complete this form as best as you can and return it. Please print clearly

Name: Bree Hopper Phone Contact: 0415530174

Have you seen your prenatal care provider since your last massage? 4

Were there any concerns at this appointment, if so what were they? n

Does your Prenatal Care Provider know you are receiving massage? Y/N

Any concerns since you have seen any Prenatal health provider that you would like to discuss?

n

Please select Y/N beside conditions as they apply recently

Uterine Bleeding Y/N Illness/ Nausea Y/N

How are you today? great!

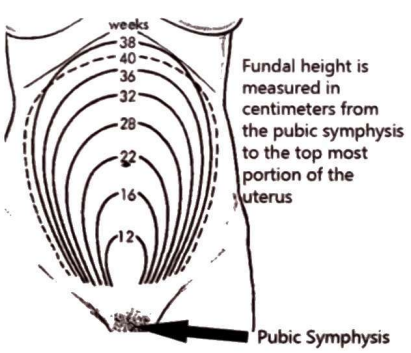
Low Back Pain Y/N Sciatica/Gluteal Pain Y/N

Hip Pain Y/N Injuries Y/N

Leg Cramps Y/N. Calves/ Hamstrings Carpal Tunnel Y/N

High Blood Pressure Y/N Headaches Y/N

Oedema/Swelling Y/N



Fundal height is measured in centimeters from the pubic symphysis to the top most portion of the uterus

Other medical conditions or injuries:

na

I understand that: In accordance with the scope of practice of a massage therapist as well as adhering to regulatory and statutory requirements it is not the role of the massage therapist to diagnose injury or illness, or prescribe medication

Signature Date: 27/9/22