Pregnancy Massage Client Form Private & Confidential

Name Briggita Chaissan

Date of Birth 30/9/89

Address 31 Huntingdale Ces Robina

Phone 0403833639 Mobile

Email briggita.jayne@gmail.com Occupation Business Owner/mum

Height 153 Weight 73

Emergency contact name and phone number Kevin Chaissan

Referred by ANL

Week of Pregnancy 32 Expected due 20/11/21

Is this your first pregnancy Y/(N) Number of children/pregnancies 2 age of children 4/2

Intended place of birth Home

Doctor/Midwife/Care provider- name and contact details Maria Nixon Midwife

Have you had pregnancy massage in this or previous pregnancies. - Details and comments

yes - both

Current medications (including vitamins, herbs, over the counter and prescription medications

Prenatal/ Supplements

Primary reason for appointment and or areas of pain

Neck, back - Migraines 10 years
TIA after 1st bub
arteries neck torn

Do you suffer from any of the following please circle yes or no

Heart/blood circulation disorders YES/NO
Spinal Disorders YES/NO
Sciatica/Gluteal pain YES/NO
Illness YES/NO
Injuries YES/NO
Surgery YES/NO
Accidents YES/NO
Osteoporosis/arthritis YES/NO
Varicose veins YES/NO
Allergies/skin problems YES/NO
Headaches YES/NO
Pain/numbness YES/NO
Bladder infection YES/NO
Uterine Bleeding YES/NO
Chronic Hypertension YES/NO
Blood clot or Phebilitis YES/NO
Placenta insufficiency YES/NO

Low back pain YES/NO
Hip Pain YES/NO
Separation of symphysis pubis YES/NO
Separation of abdominal Muscles YES/NO
Leg cramps YES/NO
Carpel tunnel YES/NO
Nausea YES/NO
High Blood Pressure YES/NO
Oedema/swelling YES/NO
Diabetes YES/NO
Preterm Labour YES/NO
Abdominal cramping YES/NO
Pre-eclampsia YES/NO
More than 2 consecutive miscarriages YES/NO
Other (please specify below) YES/NO

Any problems experience in current or past pregnancies

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Any family history of any of the conditions mentioned above: Yes or No - If yes please specify

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How many hours sleep per night? 8 Sports/Activities Walking

I consent. to pregnancy massage and will advise this practice of any changes which may affect my current treatment approach. My therapist has explained the intended treatment risks and benefits

Signed [signature] Date 27/09/21

Which Private Health Fund are you in —

Would you like to be included to our mailing list. YES/NO