**Confidential New Patient Questionnaire – Pregnancy Massage**

*Please answer all questions thoroughly as this will help us to assess your needs. If you have any questions please do ask.*

Name.……………………………………...................................................................(Mrs/ Miss/ Ms/ Dr/ Other)

Address………………………………………………………………………………………………………………….

…………………………………………………………………………………………………….……………………....

Postcode………………………………………………... Date of birth ……………………….………………

Telephone(home)………………............………….............Mobile……………….........................................

Emergency phone contact.……………………………………………………………………………………………

Email Address ………………………………………………. Occupation …………………………..……………

**Expected delivery date……………………….**

**Pre-natal care provider/Doctor………………………………………Telephone/Surgery…………………**

**This is my ………(1st, 2nd etc) pregnancy. I am …….. weeks pregnant in my ……..trimester.**

Are you currentlyseeing a Doctor, Specialist or Therapist for ANY other reason? Yes/ No

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…………………………………………………………………………………………………………………………….

Taking medication, prescribed or otherwise? Yes/ No

…………………………………………………………………………………………………………………………….

Have you had any serious or chronic illness, operations or accidents?..........................................................

*…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………*

Do you exercise?.......................................................................................How many times a week?...............

Please tick as appropriate

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Now**  | **In past**  | **Please provide further details** |
| **\*Leaking amniotic fluid or vaginal bleeding \*** |  |  |  |
| **\*Bladder Infection\*** |  |  |  |
| **\*Uterine bleeding\*** |  |  |  |
| **\*Blood clot or phlebitis\*** |  |  |  |
| **\*Chronic hypertension\*** |  |  |  |
| **\*Abdominal cramping\*** |  |  |  |
| **\*High blood pressure\*** |  |  |  |
| **\*Miscarriage\*** |  |  |  |
| **\*Problems with placenta\*** |  |  |  |
| **\*Pre-term labour\*** |  |  |  |
| **\*Pre-eclampsia\*** |  |  |  |
| **\*Visual disturbances\*** |  |  |  |
| Anaemia |  |  |  |
| Diabetes |  |  |  |
| Oedema/swelling |  |  |  |
| Fatigue |  |  |  |
| Headaches |  |  |  |
| Insomnia |  |  |  |
| Leg cramps |  |  |  |
| Heartburn |  |  |  |
| Nausea |  |  |  |
| Sciatica |  |  |  |
| Separation of the rectus muscles |  |  |  |
| Separation of the symphysis pubis |  |  |  |
| Skin disorders/athletes foot |  |  |  |
| Excess thirst |  |  |  |
| Varicose veins |  |  |  |
| Previous cesarean birth |  |  |  |
| Contagious conditions |  |  |  |
| Muscle sprain/strain |  |  |  |
| Heart attack/stroke |  |  |  |
| Constipation |  |  |  |
| Carpal tunnel syndrome |  |  |  |
| Allergies |  |  |  |
| Low blood pressure |  |  |  |
| Morning sickness |  |  |  |
| Anxiety, stress |  |  |  |
| Breathlessness |  |  |  |

Any other conditions or problems in current or past pregnancy?...................................................................

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Anything else you would like me to know?......................................................................................................

I am experiencing a low risk/high risk (circle one) pregnancy according to my doctor/midwife.

If I am currently having or develop any conditions or symptoms **highlighted above (\*)** I will discuss the condition with my massage therapist, and will have a medical release for massage signed by my pre-natal care provider before continuing with massage treatment.

This information I give is true to the best of my knowledge. I understand that massage is a health aid and does not take place of any medical care. Any information exchanged is confidential and is only used to provide a better health care service.

**Client signature………………………………………………… Date…………**