BodyWise Massage Therapy
AN EMBODIMENT PRACTICE

Prenatal Health History Form

Name:_____**Date of Birth:**_____

Childbearing History

Is this your first pregnancy? _____Any history of miscarriage? _____

Names and ages of other children_____

Any difficulty conceiving? _____ Any special technology used? _____

Have you ever had postpartum depression? _____ Mother/Sisters? _____

History of This Pregnancy

Estimated Due Date (EDD)_____

How have you been feeling? Any medical complications? Please describe:

_____

_____

_____

Please check any symptoms that apply now:

- ☐ Acid Indigestion
- ☐ Anxiety
- ☐ Carpal Tunnel Syndrome
- ☐ Constipation/Diarrhea
- ☐ Fatigue/Tiredness
- ☐ Hemorrhoids
- ☐ Incontinence
- ☐ Lack of Sleep
- ☐ Muscle Cramps
- ☐ Nausea and/or Vomiting
- ☐ Shortness of Breath
- ☐ Swelling

Body areas that need focus:

_____

_____

Please describe your self-care/comfort measures during this pregnancy:

_____

_____

_____

Health Care Providers

Primary Provider (Midwife/ObGYN) _____

Phone _____ Planned Place of Birth _____

Name and contact of other health care providers you see (chiropractic, acupuncture, homeopathy, psychotherapist, etc.)

_____

_____

Client Initials:_____

Prenatal Screening

Have you had any ultrasounds? _____ Other prenatal screening?_____
Please describe any findings (other than baby's sex, if you do not wish to disclose):
_____
_____
Is your pregnancy classified as "high risk"? _____ Please describe below:
_____
_____

Resources

Have you or will you be taking a childbirth education class?_____Please describe:
_____
_____

Will you or do you have postpartum support in place after you have given birth?_____
Please describe: _____
_____
_____

Do you have any pregnancy or birth-related questions for your massage therapist?
_____
_____
_____
_____

We have many resources available for our pregnant clients.
Please let us know how we can best support you!