

# INTEGRATIVE PREGNANCY MASSAGE

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Birthday: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Numbers: (C) \_\_\_\_\_ (H) \_\_\_\_\_  
Emergency Contact & Phone #: \_\_\_\_\_  
Email: \_\_\_\_\_

Do you have Insurance:  Yes  No  
Does it cover Massage:  Yes  No  Unsure Please check  
Name of primary OB/GYN Midwife handling your care: \_\_\_\_\_  
Phone: \_\_\_\_\_

What is your due date: \_\_\_\_\_  
How many weeks pregnant are you today? \_\_\_\_\_  
Do currently have any complications or medical issues with your  
pregnancy? No / Yes If yes. Please describe:  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any swelling?  Yes  No  Sometimes

Do you have any changes in veins?  Yes  No  
If so, where: \_\_\_\_\_

Have you been pregnant before?  Yes  No # of times \_\_\_\_\_  
Type of births you have had in the past:  
cesarean/vaginal/hospital/home/birthing center

Where are you planning to give birth? Circle all that apply  
Home birth Birthing Home Hospital

Will you be attempting a V-BAC(vaginal birth after cesarean)  
\_\_\_\_\_

Tell me what you would like to address in the session today and list  
areas of concern: