



**Massage intake form**

Today's date \_\_\_\_\_

Mother's name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ How you heard about us: \_\_\_\_\_

Most of my day is spent: Standing Sitting with/Computer Other: \_\_\_\_\_

Exercise? Y or N What kind: \_\_\_\_\_ How often: \_\_\_\_\_ per week

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

OB/GYN: \_\_\_\_\_ Phone: \_\_\_\_\_

Estimated Due Date: \_\_\_\_\_ Induction Date: \_\_\_\_\_

Planned C-Section Date: \_\_\_\_\_

I am \_\_\_\_\_(number) weeks pregnant in my \_\_\_\_\_ trimester.

Have you ever received a professional massage before? \_\_\_\_\_ How recently? \_\_\_\_\_

List any medications you are currently taking an for what condition: \_\_\_\_\_

\_\_\_\_\_

Have you had any serious or chronic illness, operations, or traumatic accident, surgeries or injuries

that I should know about? \_\_\_\_\_

\_\_\_\_\_

Are you allergic to any oils? Which ones? \_\_\_\_\_



Stork & Sprout  
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I am experiencing a **low risk / high risk** (circle one) pregnancy according to my doctor/midwife. If I am currently having or develop complications I will discuss the condition with my massage therapist, and I will have a medical release for massage signed by my prenatal care provider before continuing massage.

I understand that massage is a health aid and does not take the place of a physician's care. Any information exchanged during a massage session is confidential and is only used to provide you with the best health care services.

**Consent for treatment:**

If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or stroke maybe adjusted to my level of comfort. Because bodywork/massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical condition and answered all questions honestly. I agreed to keep the practitioner updated as to any changes in my medical profile and I understand that there shall be no liability on the practitioners' part should I fail to do so. I also understand that any elicited or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

**Cancellation policy:** I understand that unanticipated events happen occasionally in everyone's life; in order to be fair to all clients, **24-hour advance notice is required** when canceling an appointment. This allows our other clients the opportunity to schedule an appointment in your place. If you are fail to make an appointment without giving 24-hour advance notice, you will be charged the full amount of your appointment.

Understanding all of this, I agree and give my consent to receive care:

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_