Emily Martin, BCST, LMT

Prenatal Client Intake

Name _____ DOB_____ DUE DATE _____

Address_____ Occupation _____

Address_____ Email _____

Emergency Phone, Contact, Relationship _____

OB/Midwife _____ Plan to deliver at _____

Please describe your current self care: _____

Have you received massage before? When was your last massage? _____
Would you like to try belly massage today? YES NO
"Belly", or abdominal massage during pregnancy is offered to address the respiratory diaphragm and anterior hips. Many clients experience deeper breathing and better sleep as well as relief of hip pain and pelvic pressure.

Please describe your intention for your session today including areas of discomfort you would like addressed:

_____

_____

_____

Please note any common pregnancy discomforts you are experiencing/have experienced:

Nausea	Cramping	Heartburn	Hip Pain
Swelling	Sleep Disruptions	Smell Sensitivity	Pubic Symphysis Pain
Light Headedness	Gestational Diabetes	Other: _____	_____

Pregnancy History

Pregnancy and birth are emotionally charged and profound experiences in a woman's life. Please share all you are comfortable sharing. The information helps me to hold deeper awareness and space of emotional, soft tissue or scar patterns that may be related to previous pregnancies.

Do you know the name/gender of your baby?_____
Number of Previous Pregnancies: _____ Number of Previous Births:_____
Birth History: (home, hospital, vaginal, csec, vbac)_____
_____

Please let me know what other modalities or support services you'd like more information on:

Craniosacral Therapy	Birth Doula	Breastfeeding support
Newborn Craniosacral Therapy	Postpartum Doula	Postpartum Massage

By signing below I certify that the above information is complete and correct. I will inform the therapist as changes occur if therapy is to be ongoing. I agree to be responsible for all financial obligations for services rendered including no show fee of $25 for appointments not cancelled 24 hours prior. I understand that neither the therapist or the facilities shared/used by the therapist are will be liable for any injuries or loss sustained to myself or property while on the premises. In addition the therapist disclaims responsibility for injury sustained during stretches or excercised that may be suggested. I will not begin excercises or stretches without first consulting my physician.

Client Signature_____Date_____ Therapist _____Date_____