



Allergies: _____

Prenatal Massage Intake Form

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone number: _____ Would you like to receive confirmation text messages or emails?

Email: _____ (circle one) Text Email Both

Occupation: _____

In case of emergency, contact: _____ # _____

Relation: _____

How were you referred to Evolve? _____

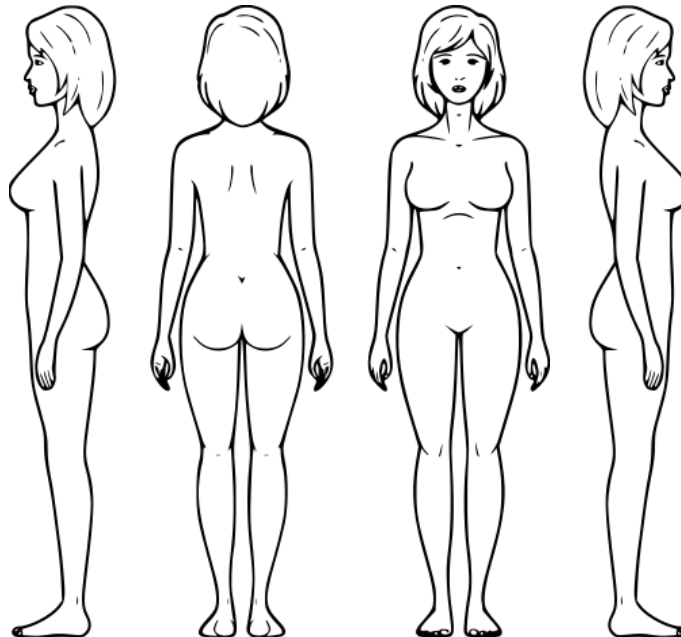
Have you ever experienced massage before? **Yes No**

If yes, when was your last massage? _____

Do you have any allergies? Yes No If yes, list them all: _____

What kind of pressure do you prefer? Light Medium Firm Deep Tissue

Using the chart below, indicate any area you are experiencing discomfort with an X.



Due Date: _____ Physician or Midwife: _____

Is this your first pregnancy? Yes No If not, how many previous pregnancies have you had? _____

Please describe how you have felt (physically and emotionally) during this pregnancy: _____

Have you had any complications or abnormalities? Yes No If yes, please describe: _____

Do you have any of the following conditions or symptoms?

Abdominal or unusual pain in the body	Yes	No	High Blood Pressure	Yes	No
Blood Clots / Phlebitis	Yes	No	Hypo/Hyper -glycemia	Yes	No
Bursitis	Yes	No	Preterm Labor	Yes	No
Decreased Fetal movement in the last 24 hours	Yes	No	Problems with Placenta	Yes	No
Diabetes (Mellitus or Gestational)	Yes	No	Sciatica	Yes	No
Diarrhea	Yes	No	Anemia	Yes	No
Excessive swelling of hands, legs, or face	Yes	No	Toxemia / Preeclampsia	Yes	No
Leaking Amniotic Fluid	Yes	No	Vaginal Bleeding and/or discharge	Yes	No
Fever	Yes	No	Varicose Veins	Yes	No

Have you eaten within the last three (3) hours? Yes No

Are you experiencing any tension or soreness in your muscles? If so, please describe. _____

Would you like your abdomen massaged? Yes No

Describe how well you sleep: _____

Describe your diet and exercise habits: _____

Is there anything else you would like to discuss regarding your pregnancy and massage? _____

Client Consent

- I am experiencing a low risk/high risk (**circle one**) pregnancy according to my doctor/midwife.
- If I am currently having or develop complications (any symptoms/conditions listed on the previous page), I will discuss the condition(s) with my massage therapist, *and will have/obtain a medical release for bodywork signed by my prenatal care provider before continuing bodywork.*
- I will immediately let my therapist know of any pain or discomfort so that pressure and strokes can be adjusted to my level of comfort.
- I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.
- I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or another qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.
- Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.
- I also understand that any illicit 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.

Client Signature: _____ **Date:** _____

Practitioner Signature: _____ **Date:** _____

Consent to Treatment of Minor:

By my signature below, I hereby authorize Evolve Massage & Wellness Center, LLC to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____

Cancellation Policy

Here at Evolve, we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment.

In our desire to be effective and fair to all of our clients, and out of consideration for our therapists' time, we have adopted the following policies:

- 24-hour notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. There will be a \$25 fee assessed to your account for any late cancellations.
- If you abuse this policy, and do not give 24 hours advanced notice, Evolve reserves the right to begin charging you the amount of your next appointment. This amount must be paid prior to your next scheduled appointment with us.

No Shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". Frequent forgetfulness or no-showing will result in being charged for the "missed" appointment and future services will be denied until payment is made.

Arriving Late

Appointment times have been arranged specifically for you. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session.

Personal Property

Evolve Massage & Wellness Center is not responsible for any items that you may leave unattended. We strongly recommend leaving expensive, personal items at home, or locked in your car. If you do bring them with you, be sure to gather all items from the treatment room prior to leaving.

Out of respect and consideration for your therapist and other customers,
please plan accordingly and be on time.

We look forward to helping you Evolve into Wellness!

Signature below confirms receipt of the cancellation policy document.

Client Name: _____

Signature: _____ **Date:** _____