PRENATAL MASSAGE HEALTH INTAKE FORM

(305) 814 9818
www.denaturawellness.com

Name: _____ Date: _____

Address:_____ Phone: _____

City/State: _____Zip Code: _____ Company:_____

Email: _____ Profession:_____

Date of Birth: _____ Emergency Contact & Phone:_____

Insurance provider: _____ Policy #: _____ Group #: _____

Primary Care Provider/Midwife/OBGYN: _____ Contact Telephone: _____

How did you hear about DeNatura Wellness? *(please circle and describe)*

Friend:_____ My office: _____ Social media: _____ Other: _____

Do you experience: *(please circle)*

Cardiovascular disease	YES	NO	Arthritis	YES	NO	Pre-term labor	YES	NO
High Blood pressure	YES	NO	Osteoporosis	YES	NO	Headaches	YES	NO
Low blood pressure	YES	NO	Spinal disorder	YES	NO	Constipation	YES	NO
Varicose veins	YES	NO	Neck pain	YES	NO	Skin disorder	YES	NO
Swelling / edema	YES	NO	Shoulder pain	YES	NO	Nausea	YES	NO
Thrombosis / phlebitis	YES	NO	Back pain	YES	NO	Hemorrhoids	YES	NO
Cancer	YES	NO	Hip/Leg/Sciatic pain	YES	NO	Sinus congestion	YES	NO
Diabetes	YES	NO	Numbness Hands/Feet	YES	NO	Heartburn	YES	NO

Other recent history:

Expected Due Date: _____ # Past Pregnancies: _____ # Births: _____ # Miscarriages: _____

Carrying Twins/Triplets: YES / NO IVF or Fertility treatment: YES / NO Are you Spotting: YES / NO

Breached baby: YES / NO Mother over 35 years of age: YES / NO Placenta Previa: YES / NO

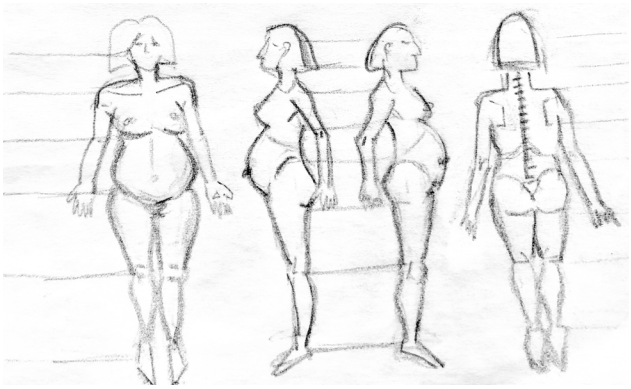
Had prenatal massage before: YES / NO History of blood clots: YES / NO Maternity leave date: _____

List any recent accidents / falls / injuries: _____

List any medications you are taking: _____

What sport do you practice? How Often? _____

Circle areas of pain / discomfort:



By signing below, I understand that it is my choice to receive and participate in a massage, stretching, physical therapy, yoga class, acupuncture treatment, guided meditation, fitness training, group class, chiropractic adjustment, wellness lecture or other service provided by DeNatura Wellness. I realize the treatment / class is for my wellbeing including stress reduction, help with trauma/addiction, tension relief, increase fitness and/or energy flow. I understand my practitioner does not diagnose illness, disease or any physical or mental disorder nor does he/she prescribe pharmaceuticals. I acknowledge that these treatments are not substitutes for medical examination and diagnosis, for which I will see my primary care provider. I will immediately inform the practitioner if I feel pain or discomfort, if I feel my wellbeing may be compromised, or if I feel the premises or equipment is unsafe. I understand that I may experience residual pain, discomfort and/or bruising after a treatment. Payment is deemed earned in full upon the commencement of services provided by DeNatura Wellness. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of my treatment/class and no refund or credit for such session will be provided. I understand and agree to be contacted by DenaturaWellness about products and services. I understand that I am liable for a one thousand dollar penalty in the event I contact or solicit services directly from the therapist/instructor without DeNatura Wellness Director's written consent, and that services may be permanently terminated should this occur. I understand and agree to all the above and waive any right I have to claim any damages or other loss or liability from DeNatura Wellness Officers, Therapists, Instructors, Speakers, Teachers Employees, Officers and/or Agents, arising out of any accident or injury, whether the same results from any active or passive negligence of DeNatura Wellness Officers, Therapists, Instructors, Speakers, Teachers, Employees, Officers and/or Agents."

PRINT NAME: _____ SIGN: _____ DATE: _____