True Health Massage Therapy
Mayte Camacho, LMT

Prenatal Massage Intake Form

Name:_____ Date:_____ DOB:_____

Address:(city, state, zip code)_____

_____

Phone number: _____

Email: _____

Referred by:_____

Marital Status

Single	Married	Divorced	Separated	Widowed	Domestic partner

Gender:_____ Age:_____ Height:_____ Weight:_____ Weeks pregnant:_____

Number of pregnancies:_____ Number of miscarriages:_____

Occupation:_____

Emergency Contact:
Name:_____ Number:_____ Relation:_____

Primary Care Physician:
Name: _____ Number: _____
Address: _____

Have you had a professional massage before?
Yes? Date of last treatment:_____ or No
Reason for visit: _____
_____
_____
_____
_____

What kind of treatments have you tried? Have they helped alleviate the problem?

Illnesses:

Surgeries:

Significant Traumas with dates (car accident, falls…)

Do you or have you ever had any infectious disease? If yes, please describe:

Allergies/Hypersensitivities:

Hobbies/Recreational Activities:

Do you exercise regularly? If yes, describe:

Any unusual stresses lately?

Favorite/least favorite time of year:

Have you traveled abroad in the last year? If so, where?

Do you smoke Y/N____ how often? ____ # per day ___ # per week, or only special occasions.

Do you drink alcohol Y/N how often? ____ oz. per day ____ oz. per week, or only special occasions.

Caffeinated drinks per day ___ or per week ____

Emotional Health: (happy, sad, chronic depression, anxiety, stressed, worried, anger, irritable, fearful, careless, etc.)

Sleep: (can't fall asleep, trouble staying asleep, frequent nighttime urination, vivid dreams, nightmares, etc.)

Body temperature: (do you run hot or cold, sweat easily, cold hands/feet)

Thirst: (crave cold or hot drinks, always or never thirsty, dry mouth or too much salivation, etc.)

In your own words, please describe the main health problems for which you are seeking treatment:

Onset:

When did this begin?

How did it happen?

When does it feel worse? Better? Do certain movements help or hurt?

What is the quality of pain? (sharp, stabby, dull, achey, sore..)

Does the pain radiate? **Yes** or **No**, if yes, where?

Is your pain constant or sporadic?

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Client initials:_____

Comparative Pain Scale

None	0	No pain. Feeling perfectly normal.
Minor Does not interfere with most activities. Able to adapt to pain psychologically and with medication or devices such as cushions	1 Very Mild 2 Discomforting 3 Tolerable	Very light barely noticeable pain, like a mosquito bite or a poison ivy itch. You rarely think about the pain. Minor pain, like light pinching the fold of skin between thumb and first finger using fingernails. Very noticeable pain, like an accidental cut, a blow to the nose causing bleeding. Pain is not so strong that you cannot get used to it. Eventually most of the time you don't notice the pain. You have adapted to it.
Moderate Interferes with many activities. Requires lifestyle changes but patient remains independent. Unable to adapt to pain.	4 Distressing 5 Very Distressing 6 Intense	Strong, deep pain, like an average toothache, or minor trauma to part of the body, such as stubbing your toe very hard. So strong you notice the pain all the time and cannot completely adapt. Note that the pain is initially piercing but becomes dull after that. Strong, deep, piercing pain, such as a sprained ankle when you stand on it wrong, or mild back pain. Not only do you notice the pain all the time, you are now so preoccupied with managing it that your normal lifestyle is curtailed. Temporary personality disorders are frequent. Strong, deep, piercing pain so strong it seems to partially dominate your senses, causing you to think somewhat unclearly. At this point you begin to have trouble holding a job or maintaining normal social relationships. Comparable to a bad non-migraine headache, several bee stings, or bad back pain.
Severe Unable to engage in normal activities. Patient is disabled and unable to function independently	7 Very Intense 8 Utterly Horrible 9 Excruciating Unbearable 10 Unimaginable Unspeakable	Same as 6 except the pain completely dominates your senses, causing you to think unclearly about half the tim. At this point you are effectively disabled and frequently cannot live alone. Comparable to an average migraine headache. Pain is so intense you can no longer think clearly at all, and have often undergone several personality changes if the pain has been present for a long time. Suicide is frequently contemplated and sometimes tried. Comparable to childbirth. Pain so intense you cannot tolerate it and demand pain killers or surgery, no matter what the side effects or risk. If this doesnt work, suicide is frequent since there is no more joy in life whatsoever. Comparable to throat cancer. Pain so intense you will go unconscious shortly. Most people have never experienced this level of pain. Those who have suffered a crushed hand, and lost consciousness as a result of the pain and not blood loss, have experienced level 10.

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Medications

(Prescriptions, over the counter, vitamins, **herbs**, etc. regularly taken in last 2 months-1 week)

Medication/Dose	Reason

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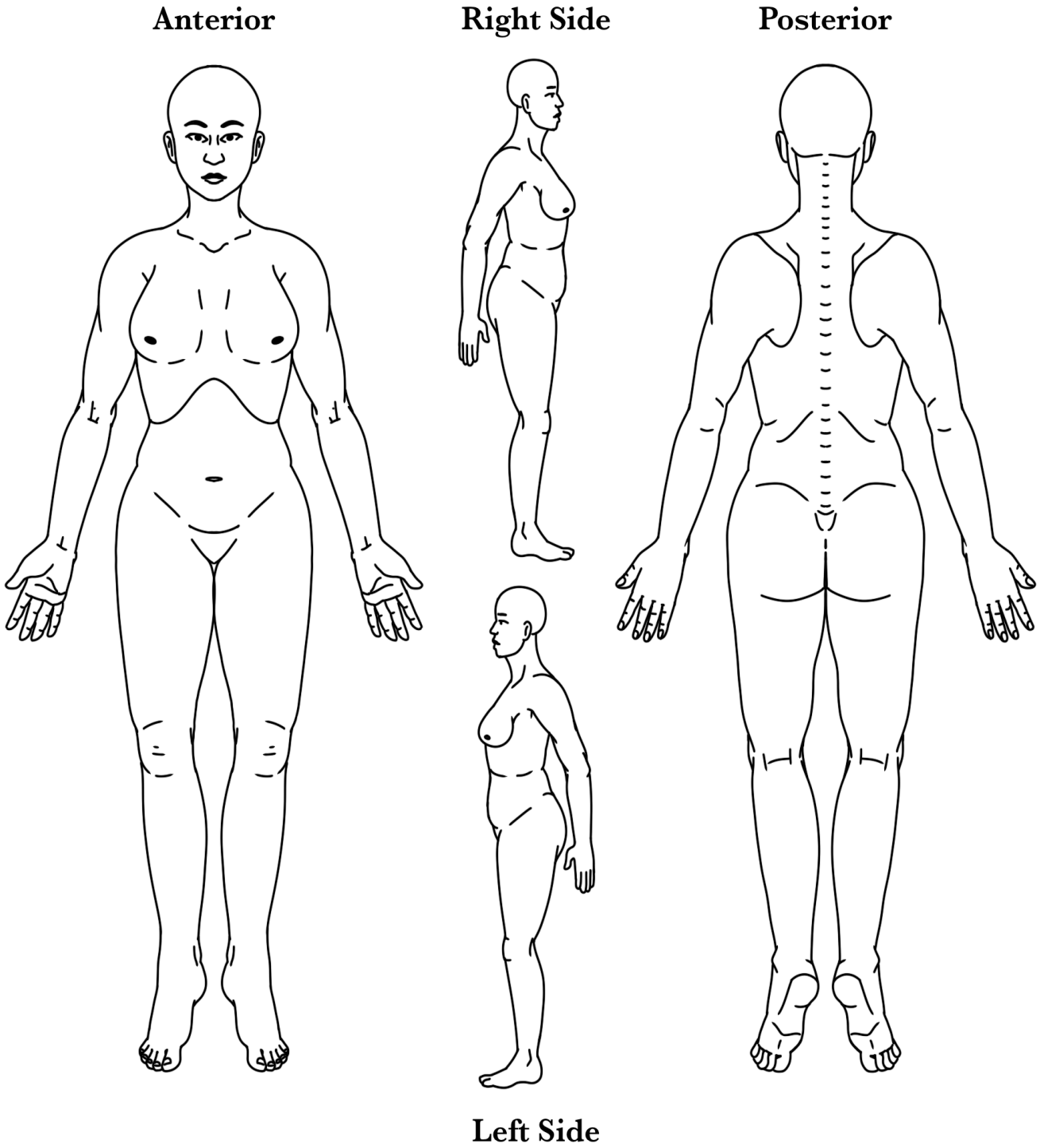

Please circle where you feel pain/discomfort. If pain is radiating, draw an arrow in the direction it is felt, from origin to end point.

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Please mark (X) for all conditions that apply now. Put (P) for past conditions, and (F) for family history of illness.

Headaches, Migraines
Ringing in ears
Vision problems
Shortness of breath
Asthma
Chronic cough
Emphysema
Frequent colds
Bronchitis
Sinusitis
High blood pressure
Low blood pressure
Heart attack
Heart disease
Varicose veins
Blood clots
Stroke
Poor circulation
Pacemaker
Herpes

Hepatitis
Infectious skin conditions
Sensory loss/change
Shingles
Seizures
numbness/tingling
Epilepsy
Multiple sclerosis
Lyme disease
HIV/AIDS
Sciatica
Tuberculosis
Arthritis
Osteoporosis
Bursitis
Tendonitis
Jaw pain, TMJ
pins/plates/wires/artificial joints
Cancer
Diabetes
Fibromyalgia

Depression
Digestive disorder
Chronic fatigue syndrome
Anxiety
Psychiatric disorder
Hearing problems, deafness
Vertigo
Dizziness
Sprains
Strains
Tumors
Spinal column disorder
Rashes/athletes foot
Fungal infection
Sleep difficulty
Hernia
Birth control/IUD
Constipation
Diarrhea
Other medical conditions not listed

Diet

List what your daily meals look like:

Morning:

Afternoon:

Evening:

List what you drink throughout the day/estimated ounces:

List any type of snacks you normally consume:

List any other food/drink consumption outside of these categories if any:

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Consent

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that Massage Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that I reserve the right to terminate, or modify the session at any time I feel necessary. **This is a Therapeutic Massage session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that she deems necessary. _____(Initials)**

Male and female genitalia and women's breasts will not be exposed or touched at any time. Draping will be used for your privacy and comfort. Our policy requires therapists to use draping with sheets/ blankets at all times during every massage session.

Please Initial: _____

Informed written consent must be provided by a parent or legal guardian for any client under the age of 17.

Signature of Client:_____ Date:_____

Signature of LMT:_____ Date:_____

Cancellation Policies

Out of respect for the therapist these are our policies for no-shows, late arrivals, and cancellations.

No-Shows:

If you are not present for the first 15 minutes of your appointment (unless you've called ahead of time about being late), you will be considered a no-show, charged a percentage of the fee, and the time slot will become available for someone else.

A second account of no-call, no-show will result in your termination as a patient based on the circumstances.

Late Arrivals:

It is required that you show up to your appointment a minimum of 5-10 minutes early to account for time needed to take notes and get comfortable on the table. New patients will require 15-20 minutes to fill out intake forms unless they were completed before the scheduled appointment.

Late arrivals will still be charged for the full amount of time requested. It is to the discretion of the therapist to extend your time or not as there may be other appointments after yours. Depending on the circumstances, some late arrivals may be excused but if lateness becomes a habit, it will result in termination of future appointments.

Cancellations:

To cancel an appointment, a minimum of 48 hours notice must be given. Less than a 48 hour notice will result in a 50% fee charge, which must be fulfilled before your next appointment. If you are able to fill your time slot with a new (paying) patient then you will not be charged for your missed appointment. If the time slot is not filled or only partially filled, then you will be charged a percentage of the fee for the time slot. Exemptions are to the discretion of the therapist and will have a limit.

-First cancellation will result in 25% fee charge

-Second cancellation will result in 50% fee charge

-Three or more cancellations will result in 100% fee charge

-More than three cancellations can result in termination of future appointments depending on the circumstances and to the discretion of the therapist.

Thank You, for your time and consideration of this practice. Please sign that you have read and understand the policies above.

Client signature:_____ Date:_____

Code of Ethics

In this setting we are committed to the highest qualities of professional health services. We are dedicated to honor, trust, attentiveness, and compassion towards our clients. That being said, there is an extensive list of our practice guidelines on the office of professions website under the topic of massage therapy.

Expectations

It is expected of the client/patient to maintain good hygiene and not use illegal drugs or alcohol before the session as this makes it unsafe for the client to receive massage. Client information is not shared with any members of the public or other healthcare providers unless the client releases the information in writing. A court of law may order the client's health-care records be released to the court as part of a legal proceeding. Therapists are obligated to report information about the abuse of a child, elderly person, or mentally or physically challenged person in the event that such information is related during the session. Therapists are obligated to report threats of self-harm, or threats that the client plans to harm another person, to authorities.

Patient signature:_____ Date:_____

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Health review/Contraindications

Please mark off if you've been recently diagnosed or suspect diagnosis of the following conditions

___ Fever

___ Nausea/diarrhea

___ Any acute vascular inflammatory condition (Buerger's disease, or phlebitis, etc.)

___ Acute stage pneumonia

___ Diabetes with complications like gangrene, advanced coronary disease, or renal disease

___High Blood Pressure

___ Low blood pressure

___ Blood clotting disorders

___ Severe hypertension

___ Menstrual bleeding

___ Recent trauma/fall

___ Heavy cramping and/or low back pain

___ Systemic contagious/infectious conditions

___ Aneurysms

___ Bleeding or spotting

___ Edema of face/hands

___ Pitting edema

___ Severe abdominal pain

___ Throbbing or migraine headaches

___ Had genetic testing done such as chorionic villi sampling

Date of test: _____

___ On bed rest (please describe why):

Please make your therapist aware of any other health conditions that are not included here, as they can affect the ability to receive massage and/or drastically change the treatment session.

Massage is both safe and beneficial to mom and baby. There is a misconception about massage and miscarriage, but there is no evidence that connects these two events, as miscarriage happens on a molecular level and/or with a severely traumatic event.

Multiple studies have revealed that massage does create a healthy environment for both mom and baby, which can promote a healthy pregnancy and even reduce the normal risks of the first trimester, as well as post-partum recovery.

***Disclaimer*:** There will be absolutely NO deep work on the legs/calves of a pregnant woman throughout the entirety of her pregnancy and 3 months post-partum. This is due to the increased risk of DVT (blood clots) and limits her to only receive lymphatic drainage on the legs. Thank you for understanding and respecting these limitations.

Some Benefits of Prenatal Massage

- Relieves musculoskeletal aches
- Supports healthy in utero environment
- Decreases chronic muscle tension, restores postural balance, normalizes joint range of motion
- Speeds up venous and lymph circulation, brings nutrients to tissues, reduces swelling, eases varicose veins, normalizes blood pressure
- Fosters deeper breathing, enhances internal respiration
- Minimizes nausea, stimulates peristaltic activity (relieves constipation)
- Elevates mood, encourages mother-baby bonding
- Reduces pain
- Prepares women physically, mentally, and emotionally for labor

And many more benefits as well. Unfortunately, stress presents itself as one of the biggest problems throughout a woman's pregnancy, and we're here to minimize the effects it has on both mom and baby. I plan on providing a calm, healing environment to give everyone their best opportunity for a beautiful birth experience.

Please sign that you have read and fully understand the risks and contraindications of prenatal massage, as well as fully informed your therapist of any and all health conditions that might affect your treatments, therefore releasing her of any legal action:

Client Signature_____ **Date:**_____

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Client initials:_____

Please read and initial each statement below:

_____ The risks and potential benefits of prenatal massage have been explained to me and I understand this information

____ I have provided my therapist with an accurate and complete medical history of myself

____ I have been given time to ask questions and have them answered to my satisfaction

____ I am experiencing a healthy pregnancy with no symptoms or contraindications listed above and/or beyond this list

____I am receiving regular medical check-ups for my pregnancy and have received clearance to participate in prenatal massage

____ I agree to communicate any discomfort experienced throughout the session

____ I understand breast tissue massage is available for prenatal care and I will only receive this massage if I personally request it

____ I release the massage therapist and business from all liability for any harm that may unintentionally result from my participation in this therapy

I understand that massage is not a substitute for medical examination or treatment, and that I should see a physician or qualified health specialist for any mental/physical ailments that occur. I understand that massage therapists do not diagnose illness or disease, and nothing said during the treatment should be interpreted as such. My consent is informed and voluntary and I understand that I may terminate my treatment at any time. By signing this form, I agree with all statements above and give my consent to proceed with prenatal massage.

Client name:_____ **Date:**_____

Client signature:_____ **Date:**_____