

KINDLE MESSAGE - INTAKE FORM

Name _____ Birth Date _____
Address _____
City _____ ST _____ Zip _____
Occupation _____
Telephone _____
Email _____

Emergency Phone Contact:

Name: _____
Relation: _____
Telephone _____

Doctor/Prenatal Care Provider _____

Telephone _____

May I have permission to contact your Care Provider? _____

Have you had a massage before? _____

If so, when was your last massage? _____

How often do you usually get a massage? _____

Are you on any medication? _____

If yes, which ones? _____

Do you exercise? _____ How many times per week? _____

Please tell us a little about yourself. Let us know what conditions and symptoms you would like us to help alleviate:

Pregnancy Specifics - cross out if not applicable

My due date is _____.

This is my _____ pregnancy.

This will be my _____ birth.

I am _____ weeks pregnant in my _____ trimester

Please check current problems - mark past conditions with 'p':

- | | |
|--|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> leaking amniotic fluid | <input type="checkbox"/> separation of the rectus muscles |
| <input type="checkbox"/> bladder infection | <input type="checkbox"/> separation of the symphysis pubis |
| <input type="checkbox"/> uterine bleeding | <input type="checkbox"/> skin disorders/athletes' foot |
| <input type="checkbox"/> blood clot or phlebitis | <input type="checkbox"/> shingles |
| <input type="checkbox"/> chronic hypertension | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> abdominal cramping | <input type="checkbox"/> visual disturbances |
| <input type="checkbox"/> gestational diabetes | <input type="checkbox"/> previous cesarean birth |
| <input type="checkbox"/> mellitus diabetes | <input type="checkbox"/> contagious conditions |
| <input type="checkbox"/> edema/swelling | <input type="checkbox"/> muscle sprain/strain |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> heart attack/stroke |
| <input type="checkbox"/> headaches | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> insomnia | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> leg cramps | <input type="checkbox"/> allergy to nut oils |
| <input type="checkbox"/> miscarriage | <input type="checkbox"/> allergy to latex |
| <input type="checkbox"/> nausea | <input type="checkbox"/> low blood pressure |
| <input type="checkbox"/> problems with placenta | <input type="checkbox"/> hypo or hyperglycemia |
| <input type="checkbox"/> pre-term labor | <input type="checkbox"/> contact lenses |
| <input type="checkbox"/> preeclampsia/toxemia | <input type="checkbox"/> other conditions or allergies |
| <input type="checkbox"/> twins/multiples | |

If you marked 'other', please specify: _____

Have you had any serious or chronic illness, operations, or traumatic accidents? _____

If yes, please explain:

Any other information that you would like us to know? _____

How did you learn about us?

Any information exchanged during a massage session is confidential and is only used to provide you with the best care possible.

I have completed this intake form to the best of my knowledge. I understand that massage is a complementary aid to my wellbeing and does not take the place of a physician's care. Kindle Massage is hereby released from all liability given the supplementary nature of their services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance. If I fail to give adequate notice or miss a scheduled appointment without giving 24 hours' notice, I agree to pay any missed appointment charges.

Name _____

Date _____