

PREGNANCY/POSTPARTUM MASSAGE THERAPY INFORMATION, INTAKE AND RELEASE

Client Name: _____ Date: _____

Due Date: _____ Phone# _____ Email _____

It is our intention to provide you a safe and nurturing experience during or after your pregnancy. There are some conditions we need to be aware of in order to modify our treatment in the best interest of you and your baby. It is our policy to work with a pregnancy or postpartum woman only if her primary healthcare provider has reviewed and approved this treatment prior to your first appointment. We are happy to help this process by faxing this release form to your primary healthcare provider.

General Information

Massage therapy during pregnancy or postpartum is not intended to replace prenatal and postpartum care.

Used as a form of adjunctive healthcare, potential benefits are:

- Reduces stress and promotes relaxation and normal blood pressure
- Relieves muscle spasms, cramps, and myofascial pain, especially in the back, neck, hips, and legs.
- Increases blood and lymph circulation and supports the physiological processes of pregnancy.
- Reduces stress on weight-bearing joints and eases musculoskeletal strain and pain.
- Provides emotional support and physical nurturance.
- Enhances a woman's kinesthetic awareness and ability to relax deeply during pregnancy and labor.
- Offers labor supportive techniques that may increase comfort during labor.
- Promotes shorter, less painful labors and reduction of complications, including prematurity, and interventions.
- Assists postpartum restoration of abdomen and weight-bearing muscles and joints.
- Provides new mothers postpartum support with the physical and emotional aspects of infant care.
- Promotes healing, including post-cesarean scars.

Pregnancy massage is beneficial throughout pregnancy. If you have or have had any of the high risk factors, complications, or conditions listed below, discuss your condition with your physician or prenatal healthcare provider. Submit the attached release at or prior to your first appointment.

Postpartum massage can begin 24 hours after delivery. If there were complications or a cesarean delivery, you must have written release from your physician or prenatal healthcare provider if you wish to receive massage in the first six weeks postpartum.

High risk factors: (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Pre-pregnancy diabetes | <input type="checkbox"/> Genetic disorder/DES exposure/uterine abnormalities |
| <input type="checkbox"/> Cardiac disorders (heart or pulmonary problems) | <input type="checkbox"/> Multiple pregnancy |
| <input type="checkbox"/> Hypertension/high blood pressure | <input type="checkbox"/> Mother's age under 20 or over 35 |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rh negative | <input type="checkbox"/> Drug/alcohol use |
| <input type="checkbox"/> Previous complications of pregnancy (see below) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Renal/liver/blood/convulsive disorders | |

Pregnancy complications: (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Fetal development complications |
| <input type="checkbox"/> Threatened miscarriage | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Early labor | <input type="checkbox"/> Pregnancy-induced hypertensive disorders (preeclampsia/eclampsia) |
| <input type="checkbox"/> Placental dysfunctions | <input type="checkbox"/> Kidney, liver, and/or bladder disorders |
| <input type="checkbox"/> Cesarean birth (recent or planned) | <input type="checkbox"/> Other |

Non-pregnancy related complications: (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Cancer or undiagnosed lumps | Contraindicated for affected areas only: |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Severe varicose veins |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Other | <input type="checkbox"/> Skin irritation and/or discharge |
| | <input type="checkbox"/> Fracture, bleeding, burns or other acute injury |

To: Client

Re: Release of liability for Prenatal/postpartum Massage Therapy

I verify that I have been informed of the possible benefits and the contraindicated conditions for massage therapy during pregnancy and postpartum. I will discuss with my physician/certified prenatal healthcare provider any health concerns that I have about massage therapy. I further verify that: (check one)

I have not had nor do I now have any prenatal complications nor any of the conditions listed on the previous page.

I have noted on the previous page all prenatal complications, risks, or conditions I am/have experienced AND I have obtained my maternity healthcare provider's release.

I understand that I will be receiving massage therapy and bodywork as a form of adjunctive health care only and that the massage therapy I receive is not a substitute for obstetric prenatal or perinatal care from a medical doctor or other licensed provider.

I hereby release and hold harmless and defend the practitioners from any claims, liability, demands and causes of action arising from my and my child's participation in this therapy.

Signature: _____ Date: _____ Print Name: _____

To: Maternity Healthcare Providers

Re: Release for Patient to Receive Therapeutic Massage During Pregnancy/Postpartum

Your patient, _____, has requested prenatal therapeutic massage. Therapeutic massage during pregnancy is provided as adjunctive health care.

It is our policy to work with a woman only if her maternity healthcare provider has reviewed this request with her. In addition, if her pregnancy is high risk, or she has experienced any complications or contraindicated conditions, we require a written release from her healthcare provider stating any specific limitations or precautions that you feel to be appropriate.

Please verify your clearance of this request by your signature below. This verification can be modified or withdrawn at any time should your patient's health status change. I welcome this opportunity to work with you in providing prenatal care to your patient. Thank you for your time and assistance.

Patient's pregnancy is: normal progression complications high risk

Specific limitations or precautions:

You may contact me directly for clarification or concerns regarding this patient. Yes No

Signature: _____ MD DO Midwife Date: _____

Please print your name: _____

Office phone: _____ (fax): _____