PREGNANCY MASSAGE INFORMED CONSENT FORM
LICENSED MASSAGE THERAPIST: Shamani Langille

First:_____ Middle:_____ Last:_____

Birthdate:_____/_____/_____ Delivery Due Date:_____/_____/_____

You are making a decision whether or not to receive a prenatal massage. Please review the following contraindications associated with this treatment. After reviewing the contraindications you may decide to cancel your prenatal massage. There will be no financial consequences associated with that action.

Name of Obstetrician/Midwife?_____ PHONE:_____

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

_____

Have you had any complications or abnormalities?_____ If yes, please describe:_____

_____

If yes, do you have the approval of your midwife or physician to receive massage?_____

Have you ever had a miscarriage?_____Yes ___No If yes, how many?_____
How far along when miscarried?_____

Do you experience or have you been diagnosed with any of the following?
_____Severe high blood pressure not medically controlled
_____Skin conditions; shingles/herpes, extreme dermatitis
_____Sunburn
_____Open sores
_____Fever or infections
_____Bloody discharge
_____Menstrual type cramping
_____Vaginal fluid abnormal discharge
If you are less than 37 weeks along in your pregnancy and are experiencing any of these symptoms, this could be a sign of premature labor. Please seek medical attention immediately.

Are you experiencing any of the following?
_____Visual disturbances
_____Severe nausea, vomiting and flu like symptoms
_____Severe headaches
_____Upper right quadrant pain
_____Swelling (edema) above mid shin VS edema around ankles
If you are experiencing any of these symptoms, this could be a sign of preeclampsia. Please seek medical attention immediately.

Your signature indicates that you have read the information provided above and have decided to receive a prenatal massage.

_____ _____
CLIENT SIGNATURE. DATE

_____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE