

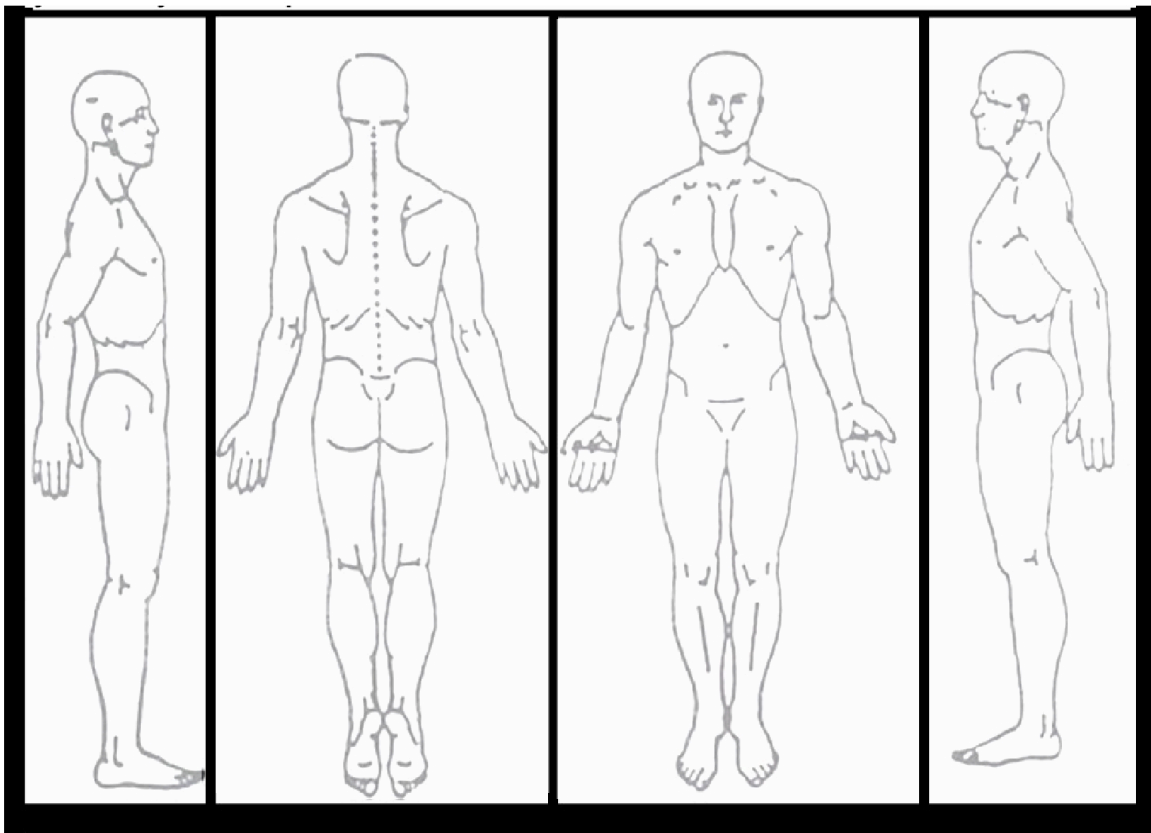
*Little Elm Massage*  
**Confidential Client Intake and Pre-Natal Health Assessment Form**

Name:		Birth date:	Delivery Date:
Address:			
City:		State:	Zip:
Email:		Would you like to receive email regarding Specials or occasional updates?	
Phone:	Cell Phone:	Occupation:	Hobbies:
OB/GYN:	Phone:	Midwife/Doula:	Phone:
Emergency Contact:	Phone:	How have you felt during this pregnancy? Circle one: <i>Excellent    Good    Fair    Uneasy/Sick most of the time</i>	

<b><i>Please check all that apply:</i></b>	√	<b><i>Please check all that apply:</i></b>	√																
Heart Trouble		Any contagious illness																	
Respiratory problems or disorders		Any alcohol in last 2 hrs																	
Diabetes		Rash, skin irritation, skin disorder																	
Arthritis / Bursitis / Rheumatism		Migraines or headaches																	
Blood clot disorders		Dizziness or fainting spells																	
Cancer		Neurological disorders																	
Fever		Spinal deviations																	
Conditions related to pregnancy:		Osteoporosis or bone disorders																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td><i>Twins</i></td><td></td></tr> <tr><td><i>Previous miscarriage</i></td><td></td></tr> <tr><td><i>Toxemia /Pre-Eclampsia</i></td><td></td></tr> <tr><td><i>Morning Sickness</i></td><td></td></tr> <tr><td><i>Decreased Fetal Movement in last 24 hrs</i></td><td></td></tr> <tr><td><i>Sensitive to odors</i></td><td></td></tr> <tr><td><i>Referral from physician</i></td><td></td></tr> <tr><td><i>Complications or risks? If so, explain at right.</i></td><td></td></tr> </table>		<i>Twins</i>		<i>Previous miscarriage</i>		<i>Toxemia /Pre-Eclampsia</i>		<i>Morning Sickness</i>		<i>Decreased Fetal Movement in last 24 hrs</i>		<i>Sensitive to odors</i>		<i>Referral from physician</i>		<i>Complications or risks? If so, explain at right.</i>		High or Low Blood Pressure	
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		Varicose Veins																	
		Bruises, cuts or open wounds																	
		Swollen tissue																	
		Other medical conditions:																	

<b><i>Please list:</i></b>	
Surgeries and/or accidents; include dates:	
Medications:	
Purpose of medications:	
Allergies, especially food allergies.	
Skin conditions:	
What has brought you to seek treatment today?	
Were you referred? If so, by whom?	
Comments:	

<b>The Texas Administrative Code, Title 25, Part 1, Chapter 141, Subchapter B, Rule 141.5, Paragraph (h) states that this initial consultation document shall include the following information:</b>	
A statement of the type of massage techniques to be used:	<i>Swedish, deep tissue, trigger point, sports, and/or Esalen style massage, for relaxation and relief of muscle pain.</i>
The massage therapist will not perform breast massage on female clients without the written consent of the client.	<i>Please discuss with your therapist.</i>
Draping will be used during the session, unless otherwise agreed to by both client and therapist.	<i>Please discuss with your therapist.</i>
A statement that if the client is uncomfortable for any reason, the client may ask the therapist to cease the massage, and the therapist will do so.	<i>As therapist, I also reserve the right to terminate the session in the event of any sort of abusive behavior from the client. If client misbehavior should result in an abbreviated session, the client will be expected to render full payment.</i>
The parts of the clients body that will be massaged or the areas of the clients body that will be avoided during the session, including indications and contraindications.	<i>On the chart below, please <b>X</b> any areas to be avoided and place an <b>CIRCLE</b> on areas that need extra attention.</i>



I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Caregiver for any conditions that I may have.

I have read and agree to the above.

Client Signature:	Date:
Stephen B Floyd, LMT, MT 109765	Date: