Post-Natal Health History

3612 Green Moss Lane, Regina, SK S4V 1M2

NAME: _____ DATE: _____
ADDRESS: _____ POSTAL CODE: _____
_____ CELL PHONE #: _____
EMERGENCY CONTACT: _____PHONE #: _____
REFERRED BY: _____
HOW MANY WEEKS POST-NATAL ARE YOU? _____
WHICH PREGNANCY IS THIS? 1 2 3 4 5
PHYSICIAN OR MIDWIFE'S NAME: _____ PHONE #: _____

HAVE YOU EVER RECEIVED MASSAGE THERAPY IN THE PAST? YES / NO

PLEASE LIST ANY HERBAL REMEDIES OR MEDICATIONS THAT YOU ARE TAKING: _____
_____
_____

WHAT DISCOMFORTS, PAIN OR OTHER NEEDS ARE YOU HOPING TO HAVE ADDRESSED THROUGH MASSAGE THERAPY? _____
_____

DID YOU HAVE ANY COMPLICATIONS WITH THIS LABOUR AND/OR DELIVERY?
PLEASE CIRCLE:

- EXTENDED ACTIVE LABOUR (< 12 HRS) PROLONGED SECOND STAGE (PUSHED < 2.5HRS)
- ASSISTED DELIVERY (VACUUM OR FORCEPS) HIGH BLOOD SUGAR
- INDUCTION EPISIOTOMY HIGH BLOOD PRESSURE DEHYDRATION
- SEVERE NAUSEA VOMITING HEADACHES HEMORRHAGING
- OTHER (Please specify) _____

DO YOU HAVE ANY EXSISTING MEDICAL CONDITIONS? PLEASE CIRCLE:

- DIABETES HEART / LUNG / KIDNEY DISORDERS
- CONVULSIVE DISORDERS UTERINE ABNORMALITY
- CONNECTIVE TISSUE OR COLLAGEN DISEASE
- ASTHMA OTHER: _____

ARE YOU CURRENTLY EXPERIENCING ANY INFECTION OR DISORDER? PLEASE CIRCLE:

- COLD BLADDER INFECTION SKIN IRRITATION
- VARICOSE VEINS OTHER: _____

SIGNATURE OF PATIENT: _____