

Prenatal 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 PREGNANT ARE YOU? _____ DUE DATE: _____

WHICH PREGNANCY IS THIS? 1 2 3 4 5

PHYSICIAN OR MIDWIFE'S NAME: _____ PHONE #: _____

ARE YOU PLANNING ON HAVING A PROFESSIONAL LABOR SUPPORT (DOULA)? YES / NO

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? _____

HAVE YOU HAD ANY COMPLICATIONS OR PROBLEMS WITH THIS PREGNANCY?

PLEASE CIRCLE:

- BLEEDING CRAMPING AMNIOTIC FLUID LEAKAGE PROTEIN IN URINE
- WATER RETENTION HIGH BLOOD PRESSURE RAPID WEIGHT GAIN
- VISION DISTURBANCES SEVERE NASEA VOMITING, HEADACHES
- ABNORMAL FETAL GROWTH HEART BEAT OR MOVEMENTS HIGH BLOOD SUGAR
- 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: _____

IS YOUR PREGNANCY CONSIDERED TO BE HIGH RISK? PLEASE CIRCLE:

- DIABETES HIGHT BLOOD PRESSURE MULTIPLE PREGNANCY
- RECENT MISCARRIAGE Rh OR GENETIC PROBLEMS IVF
- UNDER 20 OR OVER 35 FETAL GENETIC DISORDERS OTHER: _____

SIGNATURE OF PATIENT: _____