Joy Cleaver, LMT, RYT 500
The DAYA Foundation
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Prenatal Intake

name_____ date_____

referred by_____

address_____

phone_____ email_____

occupation_____ birthday_____

emergency contact_____ phone_____

week of pregnancy _____ estimated due date_____

planned birth place _____ prenatal healthcare provider_____

I have had ___ pregnancies and ___ previous births. I am carrying ___ one baby ____ multiples.

Please mark past (p) or current (c) to any conditions that may apply to your experience in this pregnancy:

___ Miscarriage	___Still Birth	___Ectopic Pregnancy
___High Blood Pressure	___Pain in Pubic Bone	___Restricted Breathing
___Carpal Tunnel Pain	___Breech Presentation	___Stiffness
___Indigestion	___Heartburn	___Morning Sickness
___Varicose Veins	___Edema (Swelling in Hands and/or Feet)	
___Sciatica/Piriformis Syndrome	___Communicable Disease	___Constipation/Gas
___Anxiety/Depression	___Uterine Abnormalities	___Placenta Praevia
___Placental Abruption	___Gestational Diabetes	___Threatened Miscarriage
___ Pre-eclampsia	___Heart Disease	___Anemia
___Difficulty Sleeping	___Headaches/Migraines	___Leg Cramps
___Low Blood Pressure	___Dizziness/Fainting	___Allergies
___Skin Disorders	___Numbness	

Are you taking any medications, vitamins, supplements?

Please list any surgeries, accidents or major illnesses within the last five years.

Please list the information regarding any hospitalizations.

What do you do to relax?

What do you do to exercise?

What are the primary sources of stress in your life?

Where in your body do you hold stress?

In regard to previous pregnancies, what was your experience of pregnancy :
Labor & Delivery: ___ Vaginal Birth ___ Cesarean Birth ___ Premature ___ Induced Birth

Postpartum:

Breast-feeding:

Postpartum Depression/Anxiety :

Is there anything else you would like me to know about your health or pregnancy?

What are your current goals for massage?

Informed Consent and Business Agreement

Full payment is due at the time of treatment. A cancellation must be made 24 hours in advance to avoid charges. You are responsible for half the cost of an appointment cancelled within 24 hours and full price of an appointment missed without cancellation. Payments must be made before receiving further treatment. In the case that you are using health or auto insurance to pay for a portion of your care in this office, arrangements may be made to omit payment and await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to 6 months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize my provider, Joy Cleaver, LMT, to release my medical records relating to claim for benefits submitted.

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I hereby give my consent to receive therapeutic massage.

Signature:_____Date:_____