300 W. Broadway, Suite 712, Council Bluffs, IA 51503 (712) 256-2561

## PREGNANCY MASSAGE INFORMED CONSENT

Name: ______________________________________ Date: ________________ 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.

Signed: ______________________________________________________________________ Date: _______________________

Signature of Parent / Legal Guardian (if necessary):________________________________ Date: ______________________