

**PREGNANCY MASSAGE INFORMED CONSENT FORM**  
**LICENSED MASSAGE THERAPIST: Shamani Langille**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ 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.

\_\_\_\_\_  
CLIENT SIGNATURE.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE