

# SUSAN GRAY WELLNESS

Susan L. Gray, RCST, LMT, CLA

Registered Craniosacral Therapist - Therapeutic Massage for Adults, Teens and Children

Specializing in Pregnancy and Labor Support Education

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## PREGNANCY INFORMATION FORM

Date: \_\_\_\_\_ Name \_\_\_\_\_ Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

E-mail: \_\_\_\_\_ Tel:(hm): \_\_\_\_\_ (cell): \_\_\_\_\_

Occupation: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Have you ever had a massage before? Y/N

Primary physician name \_\_\_\_\_ Tel: \_\_\_\_\_

Physician approval of massage Y/N. Week of pregnancy \_\_\_\_\_ Due Date \_\_\_\_\_

Please list past history with pregnancy and birth/miscarriage or other complications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List areas of complaint, pain or tension: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medication you are taking (including aspirin): \_\_\_\_\_

Please (date/describe) any accidents or operations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please circle any of the symptoms or physical problems listed below that you are currently experiencing or have experienced:

Allergies	Arthritis	Heart Condition	Cancer
Blood Clot	Varicose veins	Diabetes	Hip Replacement
Joint disease	Spinal Problems	Insomnia	High/Low blood pressure
Respiratory/lung	Numbness	Scoliosis	Fatigue
Headaches	Sciatica	Fractures	Broken ribs

Any history of pre-eclampsia? y/n \_\_\_\_\_

Skin problems/rashes, please specify \_\_\_\_\_

Do you exercise regularly? Y/N If yes, what exercise are doing during your pregnancy? \_\_\_\_\_

PRE-NATAL INTAKE (CONTINUED)

Describe your diet? \_\_\_\_\_

Please list any hereditary disorders or diseases of immediate family member:  
(such as heart disease, scoliosis, multiple sclerosis, etc.)

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_

How many glasses of water do you drink per day?

How many hours of sleep do you average at night?

Is there any other medical information that I should know before proceeding with  
massage? \_\_\_\_\_

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I am having a normal pregnancy and I hereby give (Susan L. Gray) permission to perform massage  
therapy on myself without any medical diagnosis. I \_\_\_\_\_,  
understand the massage therapy is for the purpose of stress reduction, relief from muscular tension,  
general relaxation and improvement of circulation.

I understand that the massage therapist does not diagnose illness, disease or any other physical or  
mental disorder. As such, the massage therapist does not prescribe medical treatment or  
pharmaceuticals, nor do they perform spinal manipulations.

It has been made clear to me that professional massage therapy is not a substitute for medical  
treatment and that it is recommended that I see a physician for any physical ailment that I might  
have.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist  
updated on my physical health.

**A \$50 cancellation fee will be charged to client without 24 hour notice.**

Signature \_\_\_\_\_ Date \_\_\_\_\_