CONSULTATION FORM

Pregnancy Massage

Date of consultation: ……. **Pregnancy (week):** ……..……

Personal Details:

Title: …… Name ……..……

Address: ……..……...

..……...…… Postcode:……..….

No. of Children and age:…….…...…..……..… Date of Birth: ….……

Profession: ……..……..Phone No: ……..…….……

E-mail: ……..…….

Primary care provider name and address:……..……..…….

…….……..……..…….……

Last visit to Primary care provider:……..……..……..…….

Next to kin (available support): …… Phone No:……...

Number of pregnancies: …… Was recent pregnancy planned? No □ Yes □

History of previous pregnancy (incl. childbirth, postnatal period): ……..

……

Do you suffer from the following?

Backache □ Morning sickness □ Heartburn □ Headaches □ Migraine □ Sinuses □

Depression □ Panic attacks □ Diarrhoea □ Constipation □ Sciatica □ Anaemia □

Asthma □ Diabetes □ Epilepsy □ Itchy skin □ Palpitation □ Oedema □

High blood pressure □ Low blood pressure □ Varicose veins □ Haemorrhoids □

Pelvic girdle instability □ Symphysis pubis laxity □ Carpal tunnel syndrome □

Skin diseases (Eczema, Acne, Dermatitis, Psoriasis, other) □ ……..

Any issues in the current pregnancy (except ones above):

Vaginal bleeding □ Abdominal pain □ Sensory loss (numbness) □ Groin pain or discomfort □

Urination problem □ Leg cramping or pain □ Clotting issue (suspected deep vein thrombosis) □

Protein, sugar or blood in urine (if known) □

Address: 5 Earlspark Crescent, Bieldside, Aberdeen, AB15 9AY
Website: www.ainetherapies.co.uk E-mail: info@ainetherapies.co.uk
Mobile: 07798 557454

Other: …….

Aids or STD: ……...……

Current medical treatment (if any):..……

Current medication (or homeopathic, vitamins):……..……

……

How would you describe your diet? (Portions/cups a day)

Veg/Fruit…… Dairy Produce…… Sweet Things….. Protein cont. food…….…….

Tea……. Coffee……. Water……. Soft Drinks…….. Other…….

Food or other allergies? No □ Yes □ ..……..……..……..

Do you smoke? No □ Yes □ Do you drink alcohol? No □ Yes □

General state of health:

Stress levels: *home:* High □ Medium □ Low □ *work*: High □ Medium □ Low □

Sleep pattern: Good □ Average □ Poor □ Ability to relax: Good □ Average □ Poor □

Working at computer: No □ Yes □ (hours daily/weekly) ……..…

Recent exercises: ……..……..……

Have you had a Complementary Treatment before? No □ Yes □ (recently?)…..……

Any other comments…… ...

Light breast massage to be included: No □ Yes □

Birth plans for this labour:……..

Client declaration:

I declare that the information I have given is correct and that as far I am aware I can undertake treatment without any adverse effects. I have been fully informed about the treatment and any contraindications and I am willing to proceed. I understand that any complementary therapy treatment does not substitute medical treatment. I agree that my data can be securely stored by A'INE Complementary Therapies, who will not share data with third parties without prior consent.

Client Signature: …….. Date: ……..

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Details of previous pregnancies (if needed)**:**

Previous pregnancies?	1	2	3	4
Was the pregnancy normal?				
Did you suffer any ailments?				
Was the delivery normal?				
Pre-term, on time, overdue?				
Were you induced?				
Did you have an epidural?				
Assisted delivery (how)?				
Did you have stitches?				
Did you breast feed?				
Any postnatal problems?				

Other notes: