My Doula-Sasha is Your Massage Momma
Client Intake Form

Name: _____ **Home #:** _____ **Cell #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Work #: _____ **Occupation:** _____ **Referred by:** _____

E-mail: _____ **Date of Birth:** _____ **Partner Name:** _____

General & Medical Information: *(If you answer "yes" to any of these questions, please explain as clearly as possible).*

☐ yes ☐ no Have you ever had a professional massage?
Do you prefer ☐ light ☐ medium ☐ deep massage pressure?
Are you pregnant? ☐ yes ☐ no Due date? _____
OB/Gyn or Midwife Name: _____
Where will you deliver? _____
Total number of previous pregnancies? _____
Vaginal _____ C-section _____ Miscarriage _____
☐ yes ☐ no Do you have any pregnancy related conditions?
☐ yes ☐ no Have you been on bed rest for any reason?
Explain: _____
☐ yes ☐ no Is this pregnancy considered high-risk?
If yes, why? _____
☐ yes ☐ no Do you suffer frequently from stress?
☐ yes ☐ no Do you experience frequent headaches?
☐ yes ☐ no Do you have high blood pressure?
If yes, are you taking medication? _____
☐ yes ☐ no Are you diabetic?
☐ yes ☐ no Do you suffer from seizures or epilepsy?
☐ yes ☐ no Do you have cardiac or circulatory problems?
☐ yes ☐ no Have you had blood clots or DVT?
☐ yes ☐ no Do you have varicose veins?
☐ yes ☐ no Do you have carpal tunnel syndrome?
☐ yes ☐ no Do you have allergies? Lotions? _____
☐ yes ☐ no Do you have any skin disorders?
☐ yes ☐ no Do you have any infectious conditions?
If yes, please explain: _____
☐ yes ☐ no Do you have cancer?
☐ yes ☐ no Do you suffer from fibromyalgia?
☐ yes ☐ no Are you depressed or have a mood disorder?
☐ yes ☐ no Do you have PMS or PMDD syndrome?
☐ yes ☐ no Are you an Abuse Survivor?
☐ yes ☐ no Are you more tense or sore in a specific area?
If yes, explain: _____
☐ yes ☐ no Do you have numbness or stabbing pain?
☐ yes ☐ no Do you have any other medical conditions?
☐ yes ☐ no Have you had surgery? Explain in comments:

If you are interested in a **Post Pregnancy after Breasting Weight Management Program**, please answer the following questions. If not skip this section and sign below. Please note that massage therapy is a part of this program, so do answer the above questions that pertain to you.

What is your current weight or clothing size?_____
What is your goal weight or clothing size after baby?_____

Life Changing Events

☐ Change in Marital Status ☐ Death or illness of family member or close friend
☐ Retirement ☐ Personal illness or injury ☐ Change of living conditions
☐ Change in recreation/social activities ☐ Change in eating habits

Which diet or weight reduction programs have you participated in the past?_____
_____

Which worked best, and why?_____
_____

When was the last time you participated in a diet or weight reduction program?_____
_____

Do you exercise now? And are you interested in yoga? Y N

If yes, what types of exercise do you like doing?_____

For how long?_____How often?_____Regular or sporadic?_____

If not, what stops you? (check all that apply)

☐ It brings up body image issues. ☐ I fear attention
☐ Low self-esteem ☐ Too tired

☐ Need to avoid my body ☐ No place / no equipment
☐ Not enough time due to new baby & other kids ☐ No one to exercise with

What are your thoughts on raw fruits and vegetables? _____
_____
_____

Additional Comments:
_____
_____

What brings you here today? _____

I use a combination of the following techniques: Swedish, Myofascial Release, Trigger Point, Accupressure and Deep Tissue Massage.

The following areas will be avoided during the massage: _____
Contraindications: _____

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED.
If you have a specific medical condition or symptoms, massage may be contraindicated. I understand the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. I understand that breast massage is only performed with written consent. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment I am aware of. *I agree to keep the therapist updated as to any changes in my medical profile.*
I agree to give 24-hour advance notice if I must cancel a scheduled appointment. If I fail to provide this notice, I understand that I will be billed for that time.

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Information and Suggestions

- Prior to your massage, remove all jewelry. Pull long hair back with a clip or ponytail holder.
- As a rule, massage is given while you are unclothed. We provide a top sheet. Modesty and comfort levels vary from person to person. You may choose to wear undergarments or nothing at all.
- During your massage, you may want to give your therapist feedback as to pressure (deeper or lighter) or point out painful or ticklish areas of your body.
- Feel free to ask your therapist any questions about their procedure. Your therapist is a highly trained professional and will be happy to make you feel well-informed and comfortable. If you are uncomfortable for any reason, ask that the session be ended.