Prenatal Massage Consent

Specialized consent for pregnancy massage with trimester-specific screening and physician clearance

Client Information

First Name *

Last Name *

Email Address *

Phone Number *

Date of Birth *

MM / DD / YYYY

Pregnancy Information

Expected Due Date *

MM / DD / YYYY

Current Trimester *

- [ ] First Trimester (weeks 1-12)
- [ ] Second Trimester (weeks 13-27)
- [ ] Third Trimester (weeks 28-40)

OB/GYN or Midwife Name *

OB/GYN Phone *

Has your physician cleared you for massage? *

- [ ] Yes
- [ ] No
- [ ] Haven't asked

Pregnancy Health Screening

Has your pregnancy been classified as high-risk? *

- [ ] Yes
- [ ] No

Are you experiencing or have you been diagnosed with any of the following?

- [ ] Preeclampsia / High blood pressure
- [ ] Placenta previa
- [ ] Blood clots / DVT
- [ ] Severe morning sickness / Hyperemesis
- [ ] Gestational diabetes
- [ ] Preterm labor risk / Cervical insufficiency
- [ ] Severe edema / Swelling
- [ ] None of the above

Where are you experiencing discomfort?

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Prenatal Massage Information:

- You will be positioned on your side with supportive pillows for comfort and safety
- Certain pressure points (ankles, wrists, between thumb and index finger) will be avoided as they may stimulate contractions
- Deep abdominal work will NOT be performed
- Essential oils that are safe for pregnancy will be used, or none if preferred
- If you experience any contractions, dizziness, or discomfort, inform your therapist immediately
- Massage during pregnancy has been shown to reduce stress, decrease muscle tension, improve circulation, and promote better sleep

I confirm that I have disclosed my full pregnancy health status and understand the guidelines for prenatal massage.

I understand the prenatal massage guidelines: _____

Session Notes

For office use only

	Date	Area	Technique	Notes
Entry 1				
Entry 2				
Entry 3				
Entry 4				
Entry 5				
Entry 6				

Consent & Signature

I consent to prenatal massage therapy. I have disclosed all pregnancy-related health conditions and understand that certain techniques and areas are modified or avoided during pregnancy. I release the therapist from liability.

I confirm I have read and understood the above information and give my informed consent.

I have read and understand the above information: _____

Signature

Date

Print name

Date *

MM / DD / YYYY