Pregnancy & postpartum massage consultation form



Therapist name:	
Your name:	
Are you currently:	
Pregnant	Postpartum
If postpartum, ple	ase specify delivery date:
If pregnant, how f	ar along are you? (weeks)
Any complication	s during this or a previous pregnancy?
Yes O	No If yes, please describe:
Have you been cle	eared for massage therapy by your doctor or midwife?
Yes	No
Do you have any o	of the following conditions? (Check all that apply)
High blood p	pressure Gestational diabetes Preeclampsia
Skin condition	ons Cancer Recent bleeding or spotting
Other:	

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Health & well-being	
Have you had a pregnancy or postpartum massage before?	
Yes No	
Do you currently have or have you ever had any of the following? (Check all that apply)	
High blood pressure Heart disease Diabetes Cancer (current or past)	
Blood clotting issues Recent surgery (within the past 6 months)	
Other:	
Do you have any allergies or skin sensitivities?	
Yes No If yes, please list:	
Are you taking any medications?	
Yes No If yes, please list:	
Consent & waiver	
I confirm that I have provided accurate and complete details about my health and pregnancy/postpartum status. I understand that massage during pregnancy or postpartum may have some risks, including but not limited to muscle soreness, swelling or sensitivity, and that I must follow any aftercare instructions provided by my therapist.	
I understand that I can stop or refuse treatment at any time and will inform the therapist if I feel any discomfort during the massage. I acknowledge that this treatment is not a substitute for medical care.	
Waiver of liability	
Urban's role is to connect me with an independent therapist, and my contract is directly with them. I release Urban and the therapist, to the extent permitted by law, from any liability related to this session.	
Date: Client signature:	

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