



**Assiram Natural Therapies
Pregnancy Massage Client Consent Form**

Name _____ Date _____

Which trimester are you in? 1st 2nd 3rd Due Date _____

Do you currently/previously have any of the following symptoms or conditions? Please tick

- High blood pressure
- Excessive swelling of hands & feet
- Preterm labor
- Previous miscarriage
- Decreased fetal movement in the past 24 hours
- Diabetes
- Toxemia
- Heart disease
- Abdominal pain

Do you have the permission from your GP/Health carer, if suffering any of the above, to receive massage treatment? Yes No

Name of GP/Health carer _____

Contact number _____

Have you had any complications or during your current/previous pregnancy? Yes No

If yes, please explain _____

Are you experiencing any muscle tension or soreness in any specific area at this time? Yes No

If yes, please specify _____

The above information I have given is true and accurate. I agree I have disclosed all other relevant information. I am aware that massage therapy is not a substitute for medical attention or examination and that I am seeking remedial therapy voluntarily for the sole purpose of treating mild discomfort and relaxation. I take full responsibility for updating my practitioner on any changes which occur throughout the duration of my pregnancy should I become a frequent client to the clinic.

I acknowledge that I have been informed of all precautions and risks associated with pregnancy massage and I have been made fully aware of the possible outcomes.

Signed _____ (Client)

Signed _____ (Therapist)



**Assiram Natural Therapies
Pregnancy Massage Client Consent Form**

Name _____ Date _____

Which trimester are you in? 1st 2nd 3rd Due Date _____

Do you currently/previously have any of the following symptoms or conditions? Please tick

- High blood pressure
- Excessive swelling of hands & feet
- Preterm labor
- Previous miscarriage
- Decreased fetal movement in the past 24 hours
- Diabetes
- Toxemia
- Heart disease
- Abdominal pain

Do you have the permission from your GP/Health carer, if suffering any of the above, to receive massage treatment? Yes No

Name of GP/Health carer _____

Contact number _____

Have you had any complications or during your current/previous pregnancy? Yes No

If yes, please explain _____

Are you experiencing any muscle tension or soreness in any specific area at this time? Yes No

If yes, please specify _____

The above information I have given is true and accurate. I agree I have disclosed all other relevant information. I am aware that massage therapy is not a substitute for medical attention or examination and that I am seeking remedial therapy voluntarily for the sole purpose of treating mild discomfort and relaxation. I take full responsibility for updating my practitioner on any changes which occur throughout the duration of my pregnancy should I become a frequent client to the clinic.

I acknowledge that I have been informed of all precautions and risks associated with pregnancy massage and I have been made fully aware of the possible outcomes.

Signed _____ (Client)

Signed _____ (Therapist)