

Client Name: _____

Date _____

PREGNANCY AND POSTPARTUM MASSAGE THERAPY RELEASE

It is my intention to provide you a safe and nurturing experience during or after your pregnancy. There are some conditions I need to be aware of in order to modify our treatment in the best interest of you and your baby. It is my policy to work with a pregnancy or postpartum woman only if her primary healthcare provider has reviewed and approved this treatment prior to your first appointment.

GENERAL INFORMATION: Massage Therapy during pregnancy or postpartum is not intended to replace prenatal and postpartum care. Used as a form of adjunctive healthcare, potential benefits are:

Reduces stress and promotes relaxation and normal blood pressure.

Relieves muscle spasms, cramps and myofascial pain, especially in the back, neck, hips and legs.

Increases blood and lymph circulation and supports the physiological processes of pregnancy.

Reduces stress on weight-bearing joints and eases musculoskeletal strain and pain.

Provides emotional support and physical nurturance.

Enhances a woman's kinesthetic awareness and her ability to relax deeply which may be helpful during labor.

Offers labor supportive techniques that may increase comfort during labor.

Promotes shorter, less painful labors and reduction of complications, including prematurity and interventions.

Assists postpartum restoration of abdomen and weight-bearing muscles and joints.

Provides new mothers postpartum support with the physical and emotional aspects of infant care.

Promotes healing, including post-cesarean scars.

Pregnancy massage is beneficial throughout pregnancy. If you have or have had any of the high-risk factors, complications or conditions listed below, discuss your condition with your Physician or prenatal healthcare provider. Submit the attached release at or prior to your first appointment.

Postpartum massage can begin 24 hours after delivery. If there were complications or cesarean delivery, you must have a written release from your Physician or prenatal healthcare provider if you wish to receive massage in the first six weeks postpartum.

HIGH RISK FACTORS: (Please circle all that apply)

Pre-pregnancy diabetes
Cardiac disorders (heart or pulmonary problems)
Hypertension / high blood pressure
Thyroid disorder
Rh negative
Previous complications of pregnancy (see below)
Genetic disorders/DES exposure/uterine abnormalities
Multiple pregnancy
Mother's age under 20 or over 35
Asthma
Drug/alcohol use
Renal/liver/blood/convulsive disorders

PREGNANCY COMPLICATIONS: (Please circle all that apply)

Gestational diabetes
Threatened miscarriage
Early labor
Placental dysfunctions
Cesarean birth (recent or planned)
Fetal development complications
Anemia
Pregnancy-induced hypertensive disorders (Preeclampsia/eclampsia/toxemia)
Kidney, liver, and or bladder disorders

NON-PREGNANCY RELATED COMPLICATIONS: (Please circle all that apply)

Cancer or undiagnosed lumps
Infection
Autoimmune disorder
Other: _____

Contraindicated for affected areas only:

Sever varicose veins
Thrombophlebitis
Skin irritation and/or discharge
Fracture, bleeding, burns or other acute injury

To: Client

Re: Release

I verify that I have been informed of the possible benefits and the contraindicated conditions for massage therapy during pregnancy and postpartum. I will discuss with my Physician/certified prenatal healthcare provider any health concerns that I have about massage therapy. I further verify that: (Check one)

I have not had nor do I now have any prenatal conditions nor any of the conditions listed on the previous page.

I have noted on the previous page all prenatal complications, risks, or conditions I am/have experienced AND I have obtained my maternity healthcare provider's release.

I understand that I will be receiving massage therapy and bodywork as a form of adjunctive health care only and that the massage therapy I receive is not a substitute for obstetric prenatal or perinatal care from a medical doctor or other licensed provider.

I hereby release and hold harmless and defend the practitioners from any claims, liability, demands and causes of actions arising from my and my child's participation in this therapy.

Signature: _____ Date: _____



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To: Maternity Healthcare Providers

Re: Release for Therapeutic Massage During Pregnancy/Postpartum

Your patient, _____, has requested prenatal therapeutic massage. Therapeutic massage during pregnancy is provided as adjunctive health care by a Licensed Massage Therapist who has been certified in Massage Therapy and is licensed by the State of Nevada.

It is my policy to work with her only if her maternity healthcare provider has reviewed this request with her. In addition, if her pregnancy is high risk, or she has experienced any complications or contraindicated conditions, I require a written release from her healthcare provider stating any specific limitations or precaution that you feel to be appropriate.

Please verify your clearance of this request by your signature below. This verification can be modified or withdrawn at any time should your patient's health status change. I welcome this opportunity to work with you in providing prenatal care to your patient. Thank you for your time and assistance.

Patient's pregnancy is: (circle one) low risk high risk

Specific limitations or precautions:

You may contact me directly for clarification or concerns regarding this patient: Yes No

Signature: _____ MD DO Midwife

Print Name: _____

Date: _____ Office Phone: _____

Additional Comments:



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