Massage Therapy Postpartum Massage Form
Atwell Family Chiropractic
1811 Virginia Avenue, Harrisonburg, VA 22802

Please fill out the following information. Please print clearly.

Name: ____________________ Date of Birth: ____________
Address: ____________________
City: ____________________ State: ____________ Zip: ____________
Phone: ____________________ E-mail Address: ____________________
Employer: ____________________ Occupation: ____________________
How did you hear about us or who may we thank for referring you? ____________________

Obstetrician or Midwife's Name and Contact Information:
____
____
May I contact him/her, in case of an emergency or if the need arises? ____________________

If you are currently have or had any of the following conditions, please check and circle them below and discuss them with your massage therapist before your massage begins.
Please also inform your massage therapist if you are currently under medical care or taking any medications.

Medical History

____ Heart Disease/Stroke/Heart Attack
____ Arteriosclerosis
____ Varicose Veins
____ Phlebitis/Blood clot/DVT
____ Carpal Tunnel Syndrome
____ Sleep Problems
____ Headaches/Migraines
____ Cancer/Malignancy/Tumor
____ Seizures/Fainting Spells
____ Tendonitis/Bursitis
____ Numbness or Tingling
____ Chemotherapy/Radiation
____ Fibromyalgia/Chronic Fatigue Syndrome
____ Keloid Scars
____ Other (Please List)

____ Osteoporosis/Scoliosis
____ Rheumatoid Arthritis
____ Herniated or Ruptured Disc
____ Hemorrhoids
____ Easy Bruising
____ Inner Ear Problems
____ Skin Rash
____ Skin Sensitivity
____ Joint Pain/Replacement/Dislocation
____ High/Low Blood Pressure
____ Recent Sprains/Strains
____ Cortisone Injection
____ Sinus Problems

____ Allergies
____ Osteoarthritis
____ AIDS/HIV
____ Fibrosis
____ Kidney Disease
____ Swelling
____ Lupus
____ Diabetes
____ Nausea/Heart Burn
____ Inflammation
____ TMJ Syndrome
____ Bed Sores
____ Carpal Tunnel

____
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____
____
____

Any recent surgeries, injuries, accidents or traumas within the past 5 years?
____
____
____
____

Please Turn Over & Finish Form →

Did you experience any problems during labor or after the birth of your child?

____

Did you have a vaginal birth or a C-section?

____

If you had a C-section, how is your caesarean scar healing? ____________________________________

Are you allergic or sensitive to any oils or fragrances? If yes, please list. ____________________________

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Please list any specific pain or discomforts you have been experiencing.

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Please list any prescriptions, herbs or over-the-counter drugs you are currently taking.

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Are you under a doctor's care for any reason?

____

May I have speak with your Doctor if the need arises? _________________________________

Physician's name and phone number: ____

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

The information I have provided is accurate and complete to the best of my knowledge. I understand that this work does not constitute medical treatment, but rather is a form of health maintenance utilizing the techniques and principles of traditional Swedish massage, Deep Tissue Therapy, Myofascial Release and Acupressure alternated safely for Post-partum Massage. I take responsibility for alerting my massage therapist to any physical conditions that would affect this treatment or of any changes in my health status, medications and therapies before the session or any future sessions.

I understand that if I am unable to keep my scheduled appointment, I must give at least 24 hour notice or I will be charged the fee for the treatment I am canceling. I also understand that if I am running late for my scheduled appointment, the amount of time that I am late will be deducted from my treatment time and I will be charged the full amount.

Signed ____ Date ____________________