

# Confidential Pregnancy Intake Form

Harmonize, LLC

## Contact Information

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_ Whom may I thank for referring you? \_\_\_\_\_

Whom should I contact in an emergency? \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

## Pregnancy

Estimated Delivery Date: \_\_\_ / \_\_\_ / \_\_\_ Current Weeks of Gestation: \_\_\_\_\_

Have you experienced any complications thus far? \_\_\_\_\_

Midwife or  Obstetrician: \_\_\_\_\_

Overall Pregnancy Experience: \_\_\_\_\_

## Health and Lifestyle

Have you received bodywork in the past?  Yes  No If yes, what kinds and how often? \_\_\_\_\_

What are your children's names and ages (if applicable)? \_\_\_\_\_

Please list any medications, supplements or herbs you are currently taking: \_\_\_\_\_

How is your appetite? \_\_\_\_\_

How is your sleep? \_\_\_\_\_

If you exercise, what type(s) of exercise do you do and how often? \_\_\_\_\_

**Please Turn Over →**

Please check any of the following conditions that you are currently experiencing:

- |  |  |
|--|--|
| <input type="checkbox"/> Anxiety                           | <input type="checkbox"/> Gestational Diabetes                                  |
| <input type="checkbox"/> Back/ Neck/ Shoulder Pain         | <input type="checkbox"/> Headaches   |
| <input type="checkbox"/> Blurred Vision                    | <input type="checkbox"/> Increased or Unusual Thirst with<br>Reduced Urination |
| <input type="checkbox"/> Breast Pain/ Tenderness           | <input type="checkbox"/> Sacral or Tailbone Pain                               |
| <input type="checkbox"/> Constipation or Diarrhea          | <input type="checkbox"/> Nausea  |
| <input type="checkbox"/> Depression                        | <input type="checkbox"/> Ongoing Abdominal Pain                                |
| <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> Skin Conditions or Infections                         |
| <input type="checkbox"/> Edema (Swelling)                  | <input type="checkbox"/> Vomiting  |
| <input type="checkbox"/> Fever over 100° F                 | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Frequent Burning During Urination |  |

Do you have a history of:

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies to Nut Oils | <input type="checkbox"/> Heavy Bleeding/ Heavy Periods       |
| <input type="checkbox"/> Autoimmune Disease(s) | <input type="checkbox"/> Infertility Challenges              |
| <input type="checkbox"/> Blood Clots           | <input type="checkbox"/> Joint Problems                      |
| <input type="checkbox"/> Bruising              | <input type="checkbox"/> Kidney Disease                      |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Miscarriage(s)                      |
| <input type="checkbox"/> Car Accident(s)       | <input type="checkbox"/> Physical, Emotional or Sexual Abuse |
| <input type="checkbox"/> Cesarean Birth        | <input type="checkbox"/> Postpartum Depression &/or Anxiety  |
| <input type="checkbox"/> Chemical Dependency   | <input type="checkbox"/> Recent Surgery                      |
| <input type="checkbox"/> Chemical Sensitivity  | <input type="checkbox"/> Respiratory Problems                |
| <input type="checkbox"/> Chronic Pain          | <input type="checkbox"/> Varicose Veins                      |
| <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Vertebral Disc Problems             |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Other: _____                        |

Do you have concerns from a previous pregnancy, labor, birth or postpartum period that you would like to address during this pregnancy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you need more support in your pregnancy, labor or postpartum?  Yes  No

**Consent to Treatment**

To the best of my knowledge, this form is accurate and complete. I have disclosed all known health conditions and will inform Kristy of any changes in my health status at the beginning of future appointments. I agree to discuss my pregnancy as it progresses and I consent to treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Harmonize Bodywork™ Informed Consent

I, \_\_\_\_\_, understand that massage therapy provided by Kristy Geffen is intended to enhance relaxation, reduce pain caused by muscle tension and adhesions, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes of our work together are specified below:

Physical and Energetic Therapeutic Support During Pregnancy and Postpartum

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I understand that massage therapy is recommended as an adjunctive healthcare and that it is not diagnostic and it does not replace medical care from a primary care provider. The treatment procedure and possible contraindications have been explained to me.

I will pay for my session in full at the time of service via cash or check unless Kristy is billing my insurance company. If I am using insurance to cover the cost of treatment, I give my consent to Kristy Geffen to share my chart notes with my insurance company. I understand that if I cancel with less than 24-hours notice I will be charged for my session, except in the case of an emergency or illness. I will not receive treatment if I have a cold or flu. If I arrive late to my appointment, I understand that the appointment will still end at the scheduled time, and I will pay for my appointment in full.

I am aware that all information shared with Kristy during my bodywork session is completely confidential. Exceptions include:

- If I have given Kristy consent to share my chart notes with my insurance company
- If I share that myself or someone I know is currently being hurt, or is in danger of being hurt

I understand that I do not have to try bodywork techniques/procedures or receive bodywork in parts of my body that I feel hesitant, unsafe or unsure about. According to Oregon state law, Kristy will keep genitalia and breasts draped at all times unless I have requested therapeutic breast massage. I am aware that I can terminate a session or end our therapeutic relationship at any time, at my own discretion.

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Signature

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Date

Kristy Geffen, LMT, RPP  
(503) 312-5878

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Portland, OR 97211