



Resilience Massage and Wellness

Prenatal Massage Release Form

Name: _____ Today's Date: _____

Due Date: _____

Please circle any of the following conditions or symptoms which may make massage therapy during pregnancy contraindicated or may require your therapist/practitioner to alter the massage.

- History of miscarriage - Preeclampsia - Gestational Diabetes - History of any high risk pregnancy - Cardiac, pulmonary, liver, or renal disorders - Drug exposure - Mother's age under 20 or over 35 - Multiples - Pitting edema - Hypertension - Epilepsy or other convulsive disorders - Genetic abnormalities - Placental or cervical dysfunction - Fetal growth retardation - Abdominal pain - Bloody discharge - Leaking of amniotic fluid - Sudden weight gain - Fever - Diarrhea - Sudden edema/swelling - Decrease in fetal movement over 24-hour period - Severe headaches - Severe nausea or vomiting

I understand the information contained on this form and confirm that (1) I am receiving medical care including regular check-ups with a licensed healthcare provider. (2) I am not experiencing and/or have not experienced any of the listed symptoms, conditions, or complications. (3) I am experiencing a low-risk pregnancy.

I will communicate with my therapist and let them know if I am feeling any discomfort or need adjustments to be made. I release the massage therapist/practitioner of any and all liability for any harm that may unintentionally occur during my treatment(s). I will notify my therapist of any changes to my or my baby's health at the start of each appointment.

Signature _____ Date _____