



BELLA VIA
Skin and Body Therapies

PREGNANCY MASSAGE INTAKE FORM

Name: _____ Age: _____ Today's Date: _____

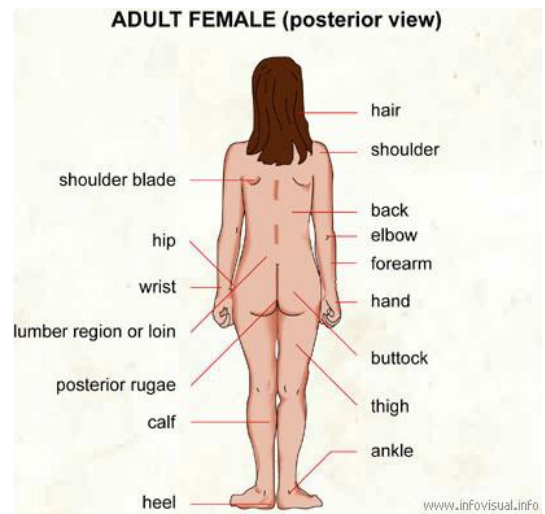
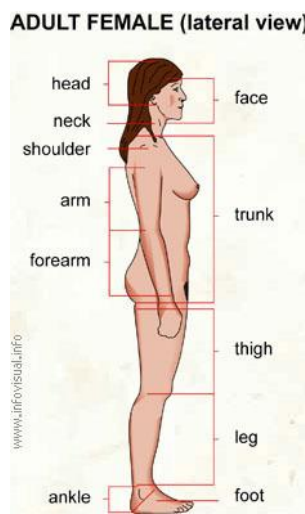
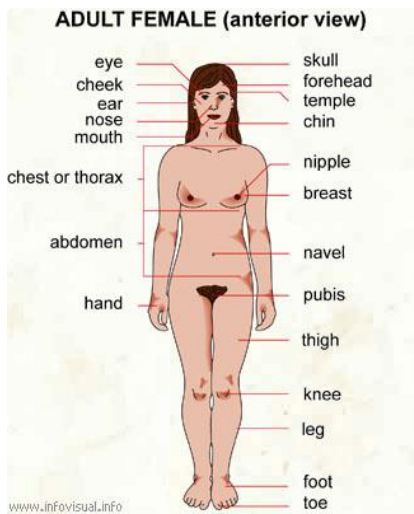
Week of Pregnancy: _____ Expected Due Date: _____

Physician: _____

Please check any complication or condition you may have experienced during this pregnancy:

- | | |
|---|--|
| <input type="checkbox"/> multiple pregnancy (twins) | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> gestational diabetes | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> placental dysfunction | <input type="checkbox"/> leg cramps |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> restless legs |
| <input type="checkbox"/> pre-eclampsia | <input type="checkbox"/> headaches |
| <input type="checkbox"/> threatened miscarriage | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> premature labor | <input type="checkbox"/> indigestion |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> constipation |
| <input type="checkbox"/> bladder infection | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> swollen hands and/or feet | <input type="checkbox"/> difficulty sleeping |

Please indicate any areas where you have tension, discomfort, or pain:



Is there any area that you would like the massage therapist to particularly focus on during your massage session?

Is there anything else you want your massage therapist to know about your health or pregnancy?

Pregnancy Massage Information and Informed Consent

Massage during pregnancy provides many benefits; It enhances circulation, supporting the work of your heart, and increasing the oxygen and nutrients delivered to your baby. It can relieve the sensation of heaviness and aching in your legs caused by swelling or varicose veins. It can optimize your muscle tone and function, relieve muscle strain and fatigue, and reduce strain in your joints. Pregnancy massage reduces stress and promotes relaxation, contributing to a healthier pregnancy. If you have been told that your pregnancy is high-risk, please notify the therapist.

Please read and sign the acknowledgment below:

I have received and read written information concerning the possible benefits of massage therapy. I verify that I am experiencing a low-risk pregnancy, and have stated all of my known medical conditions. I understand that I will be receiving massage therapy for the purpose of stress reduction, relief from muscle tension or spasm, and/or for an increase in circulation and energy flow. I understand that the massage therapist does not diagnose illness, and, as such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does she perform any spinal manipulations. I am aware that this massage is not a substitute for medical examination/diagnosis and that it is recommended that I see a physician for any ailment that I may have. I understand and I agree that I am receiving massage therapy entirely at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy, I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Signature: _____

Date: _____

Thank you for visiting Bella Via!



Affiliated with Reconstructive &
Aesthetic Surgeons, Inc.
419.534.6551 • www.RASInet.com

Craig W. Colville, M.D., F.A.C.S.
John F. Zavell, M.D., F.A.C.S.



BELLA VIA
Skin and Body Therapies

BODY THERAPIES INTAKE FORM

Name: _____ DOB: _____ Age: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____ Occupation: _____

(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you originally referred to Bella Via? (Please circle and add note if applicable.)

Dr. Colville _____ Dr. Zavell _____ Website _____ Friend: _____

Other: _____

MEDICAL HISTORY

Please check any of the following conditions that apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Cancer: type _____ |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema/Psoriasis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Immune Deficiency Disease | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Lymph Node Removal |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Nail/Foot Fungus | <input type="checkbox"/> Open Wounds/Infections |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Torn Rotator Cuff | <input type="checkbox"/> Varicose Veins |

Do you suffer from excessive stress or depression? If yes, please explain: _____

Do you have circulation problems or do you bruise easily? _____

Do you have any allergies to lotions/oils, seaweed/iodine, or medications? _____

Have you ever had a stroke or any other major injury? If yes, please explain: _____

Do you wear contact lenses? _____

Are you pregnant? If yes, when is your expected due date? _____

Are you breast-feeding? _____

Do you participate in physical/sports activities? If yes, which types and how often? _____

List all surgeries you have had within the last five years: _____

List any medications, herbals, and vitamins that you are currently taking: _____

Do you have any other medical condition(s) that your technician/therapist should know about? If yes, please explain: _____

OCCUPATIONAL CONCERNS

Please check any of the following conditions that apply to you:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heavy lifting | <input type="checkbox"/> Hazardous substances | <input type="checkbox"/> Computer work |
| <input type="checkbox"/> Repetitive functions | <input type="checkbox"/> Prolonged sitting | <input type="checkbox"/> Prolonged standing |

BODY SPECIFICS

What are your expectations of the body treatment you will receive today? _____

Do you prefer a light or firm touch with your massage? _____

Are you interested in aromatherapy incorporated into your treatment today? _____

Do you prefer a full-body massage, or do you have specific muscle groups that you would like your therapist to focus on during your massage? _____

Where are your specific areas of complaint, pain or tension? _____

Have you had a professional massage before? _____

 If yes, when? _____

 If yes, do you receive massages on a regular basis? _____

Do you have any spinal problems? _____

Are you especially sensitive to touch/pressure in any specific areas? _____

Do you have difficulty falling asleep at night? _____

Do you get muscle cramps? If yes, where? _____

By signing below, I agree to the following statement:

I understand that my body therapy session is provided for the basic purpose of stress reduction, relief from muscular discomfort, and for help in increasing blood, lymph, and energy circulation. I understand that I may experience temporary bruising or soreness with deep tissue or therapeutic massage. I have stated all known medical conditions and I will keep the massage therapist updated on any changes regarding my health. I claim full responsibility for services rendered.

Signature: _____

Date: _____

Thank you for visiting Bella Via!



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