Northcote Chiropractic Clinic

PREGNANCY MASSAGE FORM

Date:

Name _____ Occupation _____

Address _____

Town _____ Postcode _____

Phone Number (Home) _____ (Mobile) _____ (Work) _____

Date of Birth_____ Age _____ Marital Status (please state) _____

Email Address _____

Emergency Contact Name _____ Emergency Contact Number_____

Children (Names and ages) _____

Whom may we thank for referring you to our office? /or/ How did you choose us?

Family / Friend (Name)_____

(Please tick) ☐ Website ☐ Facebook ☐ Workshop ☐ Health Practitioner ☐ Walk-in ☐ Print Advertisement ☐ Other _____

PREGNANCY HEALTH – FILL IN ALL AREAS

Due Date:	Last Mw / Dr / Ob visit:
Weeks pregnant	Any guideance or advice given from them:
Blood pressure: ☐H ☐N ☐L	
Date BP last taken:	

Have you experienced any of the following:	
☐Bleeding	☐Groin pain / discomfort
☐Abdominal pain	☐Skin disorders
☐Problems with urination	☐Varicose veins
☐Regular / irregular bowel movements	☐Previous miscarriage

Pregnancy so far: Issues or symptoms:
(Continue overleaf in space provided if needed)

Position of baby: *(from 28 weeks)*
Feeling any movements?

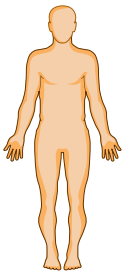
How are you feeling in general:

HEALTH CONCERNS – FILL IN ALL AREAS

Please Tick (√) all that you have experienced in the last 3 months:

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ **Back pain** *(tick area)*
- ☐ Upper ☐ Mid ☐ Low
- ☐ Balance/Coordination
- ☐ Bladder
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Chronic Fatigue
- ☐ Colds
- ☐ Congestion
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Ear Infections/Aches
- ☐ Epilepsy/Seizure
- ☐ Food Allergies
- ☐ Gallbladder issues
- ☐ G.I. Issues
- ☐ Hand/Wrist Pain
- ☐ **Headaches**
- ☐ Heart Disease
- ☐ Hernias
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ Irregular Cycles
- ☐ Kidney issues
- ☐ Knee/Ankle/Foot Pain
- ☐ **Migraines**
- ☐ **Neck/Shoulder Pain**
- ☐ Pneumonia/Bronchitis
- ☐ Poor Circulation
- ☐ Reflux
- ☐ Reproductive issues
- ☐ Sensory Processing / Spectrum disorder
- ☐ Skin issues
- ☐ Sleep issues
- ☐ Speech problems
- ☐ Thyroid issues
- ☐ Tinnitus/Ringing Ears
- ☐ Vertigo
- ☐ Other

Where is the problem? Please circle or draw on the illustrations and explain or describe your present condition in the lines below *(i.e. sharp, dull, burning, tight, throbbing)*

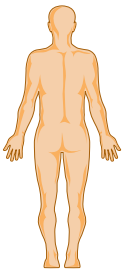


Front

_____

_____

_____



Back

_____

_____

_____

Are you taking any prescription medication? ☐No. ☐Yes. If yes, please list:_____

_____

Are you taking other Medication/Supplements? ☐No. ☐Yes.

Have you had any accidents or been in hospital? ☐No. ☐Yes. Please List._____

_____

How would you rate your stress level? ☐Low. ☐Mod. ☐High

Is there anything else you would like to ask or inform us of?_____

Have you had a massage before? ☐No. ☐Yes.

Please tick preferred massage technique and main goal: ☐Swedish massage ☐Sports massage ☐Aromatherapy massage

☐Deep tissue ☐Relaxation, Stress Reduction ☐Relieve muscle tension of areas circled on the above diagram.

INFORMED CONSENT

I, _____(print name) I have answered the Pregnancy Massage questions to the best of my ability, I understand that the massage therapy doesn't include medical diagnosis. I give my consent to undergo a massage session.
** *Please note our Doctors of Chiropractic can give a medical diagnosis, please ask at reception if you would like to see one of our Chiropractors.*

Signature_____ Date _____

Patient Signature (Legal Guardian)

NORTHCOTE HEALTH SERVICES LIMITED GDPR CONSENT

In order to continue storing and using your data, we require your consent to do so. We use your personal information for the following purposes: To keep patients informed by post, email or telephone (including SMS) on appointments, clinic information and events and offers. This includes correspondence about subscriptions, care plans, appointment reminders, clinic staffing updates and opening times, newsletters, publicity about future social & clinic events, etc. and for other reasonable purposes, always acting within the limits of the General Data Protection Regulation.

We will never will never sell, rent, loan or share your personal data with a third party for the purpose of marketing activity of any nature, unless you have provided us with explicit permission to do so. A copy of our Privacy Policy is available on the Clinic website and from the Clinic reception. You can withdraw your consent at any time by emailing **manager@northcotechiropractic.co.uk** or using the unsubscribing link contained at the bottom of all email communications received by the Clinic.

☐ I give my consent for Northcote Chiropractic to continue to store and use my data

☐ I do not give my consent for Northcote Chiropractic to continue to store and use my data

Signature_____ Date _____

Patient Signature (Legal Guardian)

MARKETING CONSENT

Northcote Chiropractic occasionally uses photographs and / or testimonials for marketing purposes. These are posted onto our social media channels i.e. Facebook, Twitter, Instagram etc. Please indicate below if you agree for us to use your photographs or comments as part of our marketing activity.

☐ I give my consent for Northcote Chiropractic to use my photographs, testimonials and comments for general marketing purposes

☐ I do not give my consent for Northcote Chiropractic to use my photographs, testimonials and comments

Signature_____ Date _____

Patient Signature (Legal Guardian)