BELLA VIA
Skin and Body Therapies

PREGNANCY MASSAGE INTAKE FORM

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

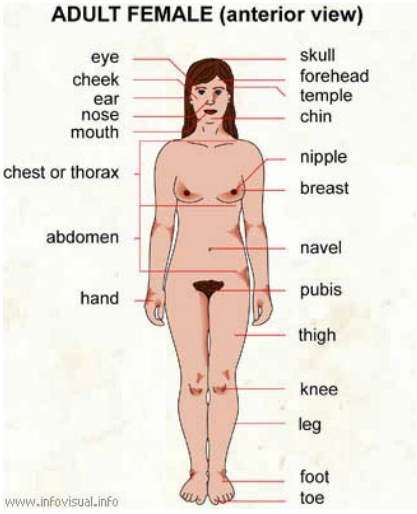
Week of Pregnancy: _____ Expected Due Date: _____

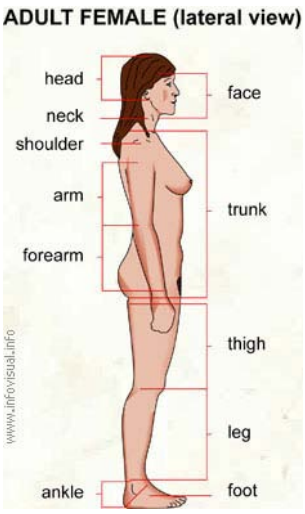
Physician: _____

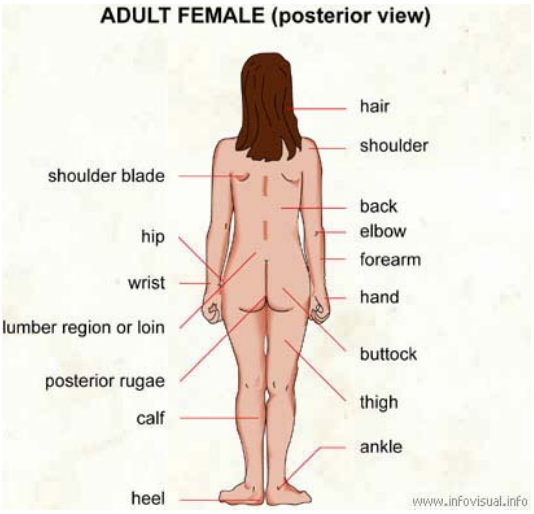
Please check any complication or condition you may have experienced during this pregnancy:

_____multiple pregnancy (twins)
_____gestational diabetes
_____placental dysfunction
_____high blood pressure
_____pre-eclampsia
_____threatened miscarriage
_____premature labor
_____heart disease
_____bladder infection
_____swollen hands and/or feet
_____varicose veins
_____phlebitis
_____leg cramps
_____restless legs
_____headaches
_____heartburn
_____indigestion
_____constipation
_____hemorrhoids
_____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.

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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:

_____Arthritis/Rheumatism	_____Asthma	_____Back Pain
_____Blood Clots	_____Bursitis	_____Cancer: type_____
_____Carpal Tunnel Syndrome	_____Diabetes	_____Eczema/Psoriasis
_____Fibromyalgia	_____Frequent Headaches	_____Heart Problems
_____Hepatitis	_____High/Low Blood Pressure	_____Infectious Disease
_____Immune Deficiency Disease	_____Joint Problems	_____Lymph Node Removal
_____Migraine Headaches	_____Nail/Foot Fungus	_____Open Wounds/Infections
_____Sciatica	_____Seasonal Allergies	_____Thyroid Condition
_____TMJ	_____Torn Rotator Cuff	_____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:

_____Heavy lifting	_____Hazardous substances	_____Computer work
_____Repetitive functions	_____Prolonged sitting	_____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 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.

I consent to having "Before" and "After" photographs of said procedure(s) for the purpose of documentation in my file. These photographs **may** _____ or **may not** _____ (please initial one) be used anonymously on our website or in our brochure for advertising purposes.

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Signature:_____ Date:_____

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