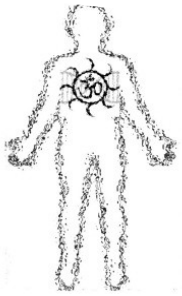


Total Tissue Energetics LLC

Prenatal Bodywork Intake and Informed Consent

You are making a decision whether or not to receive a prenatal massage.
Please review the following contraindications associated with this treatment.
After reviewing the contraindications you may decide to cancel your prenatal massage. There will be no financial consequences associated with that action.

Name: _____ Phone: _____

Address:_____

Today's Date:_____DOB:_____

Allergies:_____

Emergency contact information:

Name: _____ Phone: _____

Relationship:_____

Physician/Healthcare Provider:

Name: _____ Phone: _____

I, _____understand the benefits and contraindications to prenatal massage.

I confirm that: (please initial next to each line)

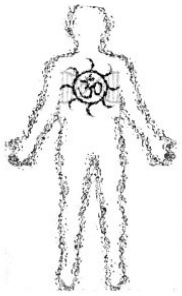
_____I am experiencing a low risk pregnancy

_____I am in my 2nd or 3rd trimester

_____I am not experiencing any health complications due to my pregnancy

_____I am receiving medical care including regular prenatal check-ups throughout my pregnancy. If my OB/GYN and I have identified any exclusion to the statements above, I will list them here:

_____



Total Tissue Energetics LLC

Prenatal Bodywork Intake and Informed Consent

What discomforts, pain or other needs are you hoping to have addressed through this bodywork session?

_____

What week of pregnancy are you?_____

Are you regularly seeing a physician, nurse-midwife or midwife? If yes, please list contact info:

_____

_____

Do you experience or have you been diagnosed with any of the following?
_____Severe high blood pressure not medically controlled
_____Skin conditions; shingles/herpes, extreme dermatitis
_____Sunburn
_____Open sores
_____Fever or infections

Are you experiencing any of the following?
_____Bloody discharge
_____Menstrual type cramping
_____Vaginal fluid dis-charge
If you are less than 37 weeks along in your pregnancy and are experiencing any of these symptoms, this could be a sign of premature labor. Please seek medical attention immediately

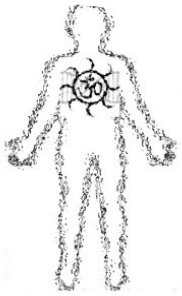
Are you experiencing any of the following?
_____Visual disturbances
_____Severe nausea, vomiting & flu like symptoms
_____Severe headaches
_____Upper right quadrant pain
_____Edema above mid shin VS edema around ankles
If you are experiencing any of the symptoms above, this could be a sign of preeclampsia. Please seek medical attention immediately.

Have you had any complications with this pregnancy?

_____

_____

Do you have any of the following medical conditions? (diabetes, heart, liver, kidney or lung disorders, uterine abnormality, other)



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Prenatal Bodywork Intake and Informed Consent

_____

_____

Are you currently experiencing any infection or disorder?(cold, bladder infection, skin irritations, varicose veins, other)

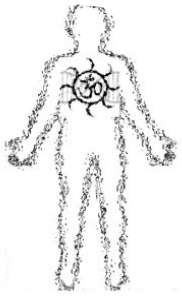
_____

_____

Is your pregnancy considered high risk? (diabetes, hypertension, multiple pregnancy, previous complicated pregnancy, asthma, Rh factor, or genetic problems, under 20 or over 35 years old)

_____

_____



Total Tissue Energetics LLC

Prenatal Bodywork Intake and Informed Consent

I understand that I will be receiving massage therapy as an adjunct to health care and that this therapy is not intended to replace appropriate medical care.

I take it upon myself to discuss the benefits of massage therapy and its risks and contraindications with my physician and the massage practitioner, and I willingly consent to and accept all the risks associated with my receiving massage therapy.

I hereby release Total Tissue Energetics LLC, JoAnn Clinton and affiliates from all liability of any nature whatsoever, whether past, present or future for any and all injury or damage which may occur to myself or my family as a result of my receiving massage therapy during the term of my pregnancy, upon delivery or thereafter.

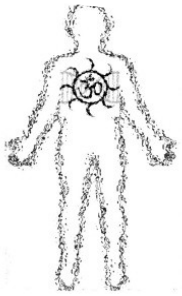
Your signature indicates that you have read the information provided above and have decided to receive a prenatal massage.

_____ _____

Signature Date

_____ _____

Print Name Date



Total Tissue Energetics LLC

Prenatal Bodywork Intake and Informed Consent

Physician's Release for Prenatal Massage:

_____, (patient) has requested therapeutic massage. These services are provided as an adjunctive healthcare. When a client's pregnancy is high risk, he or she has expected complication or contraindicated conditions; it is our policy to work with her only if her primary care physician has reviewed this request. Please verify your clearance of this request by your signature below. Please list any precautions or limitations which you feel to be appropriate. Thank you for your attention to this matter.

Precautions/Limitations:

_____

Physician's signature_____

Physician's Name Printed: _____

Date: _____