Prenatal Massage Medical Clearance Form

Client Information

Name

Date of Birth

Phone Number

Email

Estimated Due Date

OB/GYN or Primary Care Provider

Medical Information

Pregnancy Status (trimester, weeks, any complications)

Relevant Medical History

Medications

To be completed by health care provider

Provider Name

Provider Contact Information

Assessment / Comments

Medical Clearance for Prenatal Massage:

If approved with caution, please provide instructions

Provider Signature

Date