PREGNANCY AND POSTPARTUM MASSAGE THERAPY RELEASE

While massage therapy during pregnancy is not intended to replace appropriate prenatal care, used as a form of adjunctive health care, some benefits are:

- Reduces stress and promotes relaxation
- Relieves muscle spasms, cramps, and myofascial pain, especially in the back, neck, hips and legs
- Increases blood and lymph circulation, increasing cellular nutrition and reducing edema
- Reduces strain on weight-bearing joints and musculo-fascial structures
- Provides emotional support and physical nurturance
- Develops the sensory awareness necessary to relax during 1st stage labor and to recruit appropriate muscles during the pushing phase
- Improves outcome of labor
- Provides a pregnant woman with the experience of loving, nurturing touch so that she may touch her own baby lovingly
- Postpartum restoration of abdomen and weight bearing muscles and joints
- Support for new mother with physical and emotional strains of mothering

If you have been told that your pregnancy is in a high risk category, please discuss massage therapy with your physician or prenatal healthcare provider, and request their written approval.

Postpartum massage therapy can begin 24 hours after delivery. If there were complications, you must have written release from your physician if you wish to receive massage in the 1st month postpartum.

If you would like to receive massage therapy during your pregnancy, *please read and sign the following release.* Together with any other releases that may be required, submit the signed form at your next appointment.

CLIENT RELEASE

To _____, *(Massage Therapist or Acupuncturist)*

I understand that I will be participating in massage therapy sessions as a form of adjunctive health care. My pregnancy has been progressing normally. My prenatal physician/health care provider is:

_____.

Signature: _____ Date: _____

Print Name: _____

PLEASE INITIAL EACH STATEMENT BELOW:
_____ I have received written information concerning the possible benefits of massage therapy during pregnancy and postpartum.
_____ Having read and understood the information on the preceding pages, I verify that I am experiencing a low risk pregnancy. I have discussed any exceptions with my physician or prenatal health care provider and have provided any additional releases requested.
_____ I understand that I will be receiving massage therapy for the purpose of stress reduction, relief from muscle tension or spasm, or for increasing circulation and energy flow.
_____I understand that the massage therapist or acupuncturist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist or acupuncturist does not prescribe medical treatment of pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that this massage is not a substitute for medical examinations/diagnosis and that it is recommended that I see a physician for any ailment that I might have.
_____I understand and 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 therapists, their principals, and agents from all claims and liability whatsoever.*
_____I have stated all my known medical conditions and have taken it upon myself to keep the massage therapist or acupuncturist updated on my physical health.

Signature: _____ Date: _____

Print Name: _____

PHYSICIAN'S RELEASE FOR THERAPEUTIC MASSAGE/BODYWORK DURING PREGNANCY

To _____, *(Massage Therapist or Acupuncturist)*

_____ *(Patient's Name)* has requested therapeutic massage and bodywork. These services are provided as adjunctive health care. When an individual's pregnancy is high risk, or she has experienced complications in her pregnancy, it is our policy to work with her only if her primary physician has reviewed this request. Please verify your clearance of this request by your signature below. Please also list any precautions or limitations which you feel to be appropriate. Thank you for your assistance.

_____

_____

_____

Signature: _____ Date: _____

Print Name: _____