Mountain Shadows Massage & Bodywork LLC

Intake Form

Personal Information

Name ____ DOB ______________________

Email ____ Phone _________________________

City/State ___________________________ How did you hear about us? _______________________

Occupation/Activities ____

Emergency Contact Name/Relation _____________________________ Phone # __________________

Medical Information

Taking any medications? ☐ no ☐ yes List Types ____

Currently pregnant? ☐ no ☐ yes How far along? ___________ Risk factors? _______________________

Suffer from chronic pain? ☐ no ☐ yes Explain ____

Orthopedic injuries? ☐ no ☐ yes Explain ____

Allergies, sensitivities, or skin conditions? ☐ no ☐ yes Explain ___________________________________

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Scoliosis
- ☐ Bruise Easily
- ☐ Varicose Veins
- ☐ Sprains or Strains
- ☐ Asthma
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack/ Heart Disease
- ☐ Kidney Dysfunction
- ☐ Blood Clots/ DVT
- ☐ Numbness
- ☐ Seizures or Epilepsy
- ☐ Lymphedema
- ☐ Vertigo

Please explain selections: ____

Massage Information

Have you had professional massage before? ☐ no ☐ yes How often? ______________________________

What type of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm ☐ Deep ☐ Unsure

Areas of focus: ____

Areas you do **NOT** want massaged? ☐ no ☐ yes List areas: __________________________________

Scents you do **NOT** like? (such as essential oils) ____

By signing below, you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client/Guardian Signature ___________________________ Date __________

Therapist Signature _________________________ Date __________