



# 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.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Bruise Easily        | <input type="checkbox"/> Headaches/Migraines  |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Varicose Veins       | <input type="checkbox"/> Vertigo              |
| <input type="checkbox"/> Fibromyalgia                | <input type="checkbox"/> Blood Clots/ DVT     | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Heart Attack/ Heart Disease | <input type="checkbox"/> Neuropathy/ Numbness | <input type="checkbox"/> Joint Replacement(s) |
| <input type="checkbox"/> High/Low Blood Pressure     | <input type="checkbox"/> Seizures or Epilepsy | <input type="checkbox"/> Scoliosis            |
| <input type="checkbox"/> Stroke                      |   |   |

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) \_\_\_\_\_

Would you like to receive one monthly email when we open the next month's schedule and share important updates? ☐ Yes ☐ No

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 \_\_\_\_\_