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

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 _____