Raúl Castro Bodywork & Massage

Client Intake Form

Personal Information (confidential)

**Please write clearly

Name _____

Phone (cell or home) _____

Address _____

City, State, Zip _____

Email _____ (Email offers & Birthday Discounts)

Date of Birth _____

Occupation _____

Emergency Contact _____

Phone _____

Who may I thank for referring you? _____

Massage Information

Are you sensitive to fragrances or perfumes? _____ yes _____ no

Do you have sensitive skin? _____ yes _____ no

Do you wear contact lenses? _____ yes _____ no

Do you exercise regularly? _____ yes _____ no

If so, what type(s)? _____

Physical History (provide as much detail as possible)

What are your common areas of pain or tension?

_____

_____

_____

Do you see a chiropractor or Acupuncturist? _____ yes _____ no

If so, how often? _____

Are you currently under medical care? _____ yes _____ no

Are you currently taking any prescription medication?

If so, for what? _____

_____

Please indicate any conditions that you have had or currently have:

_____ headaches, migraines	_____ pregnant (currently)
_____ allergies, sensitivity	_____ I.U.D.
_____ arthritis, tendonitis	_____ blood clots
_____ cancer, tumors	_____ neck / back injuries
_____ TMJ problems	_____ diabetes
_____ abnormal skin condition	_____ paralysis
_____ heart/circulation problems	_____ fibromyalgia
_____ joint replacement / surgery	_____ sprains, strains
_____ high / low blood pressure	_____ recent injuries
_____ major accident	_____ lack of or reduced feeling / sensation
_____ varicose veins	

Explain any conditions that you have marked above:

_____

_____

_____

Informed Consent and Massage Policies (Please read & initial)

I understand that the massage is for the purpose of stress reduction, relief from muscular tension or spasm. _____

I understand that the massage therapist does not diagnose illness, disease, or any furtherphysical or mental disorders. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. _____

I understand that massage is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical ailments that I may have. _____

I understand that it is my responsibility to inform the massage therapist of any changes to this information. _____

I understand that if I experience any unusual discomfort during my massage sessions it is my responsibility to verbally inform the massage therapist at the time that it is being experienced so that they can adjust the pressure or technique being used. _____

I understand that there is no stated or implied guarantee of success or effectiveness for bodywork/massage sessions. It is my choice to receive bodywork/massage and I give my consent for bodywork/massage. _____

Cancellation Policy - Your appointment time has been set aside especially for you. A 24 hour cancellation notice is required if you are unable to keep the appointment. If I do not receive 24 hour notice you will be sent a bill for 50% of the cost for the missed appointment, and in the future you will be required to give a credit card when booking your appointment.

I agree to notify Raul Castro by phone with at least 24 hours notice if I am currently feeling sick, or have been sick within the past 7 days (ie. Flu, cold etc.) I understand that my appointment may have to be rescheduled until any illness has passed. Likewise, I understand that if the massage therapist is feeling unwell I may have to postpone my appointment for a later date and time. _____

Privacy Policy - All written records and massage sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities

without explicit written consent from the client (you) or the client's legal guardian. Unless legally required by local, state, or federal subpoena,summons, or other court order. _____

I acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. _____

Client Signature _____ Date _____

_____ Massage Therapist Signature

_____ Date

_____

Manual Therapist

SOAP CHART

Patient Name _____ Date _____

Date of Injury _____ ID#/DOB _____ Meds _____

S Focus/Health Concerns: Prioritize

Symptoms: Location/Intensity/Frequency/Duration/Onset

Activities of Daily Living: Aggravating/Relieving

O Findings: Visual/Palpable/Test Results

Techniques/Modalities: Locations/Duration

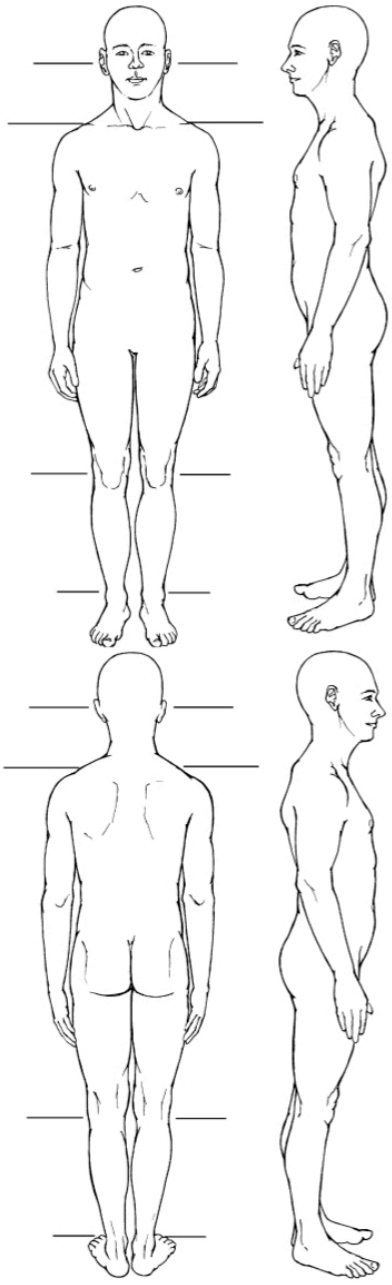
Response to Treatment (see Δ)

A Goals: Long-term/Short-term

Functional Outcomes

P Future Treatment/Frequency

Homework/Self-care



Therapist's Signature _____ Date _____

Legend: ⊚ TP • TeP ○ Ⓟ ✳ Infl ≡ HT ≈ SP

╳ Adh ≪ Numb ⟲ rot ⟋ elev ⟝ Short ⟷ Long