

# 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? \_\_\_\_\_

### MESSAGE 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:

<input type="checkbox"/> HEADACHES, MIGRAINES	<input type="checkbox"/> PREGNANT (CURRENTLY)
<input type="checkbox"/> ALLERGIES, SENSITIVITY	<input type="checkbox"/> I.U.D.
<input type="checkbox"/> ARTHRITIS, TENDONITIS	<input type="checkbox"/> BLOOD CLOTS
<input type="checkbox"/> CANCER, TUMORS	<input type="checkbox"/> NECK / BACK INJURIES
<input type="checkbox"/> TMJ PROBLEMS	<input type="checkbox"/> DIABETES
<input type="checkbox"/> ABNORMAL SKIN CONDITION	<input type="checkbox"/> PARALYSIS
<input type="checkbox"/> HEART/CIRCULATION PROBLEMS	<input type="checkbox"/> FIBROMYALGIA
<input type="checkbox"/> JOINT REPLACEMENT / SURGERY	<input type="checkbox"/> SPRAINS, STRAINS
<input type="checkbox"/> HIGH / LOW BLOOD PRESSURE	<input type="checkbox"/> RECENT INJURIES
<input type="checkbox"/> MAJOR ACCIDENT	<input type="checkbox"/> LACK OF OR REDUCED FEELING / SENSATION
<input type="checkbox"/> 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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
MESSAGE THERAPIST SIGNATURE  
DATE

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

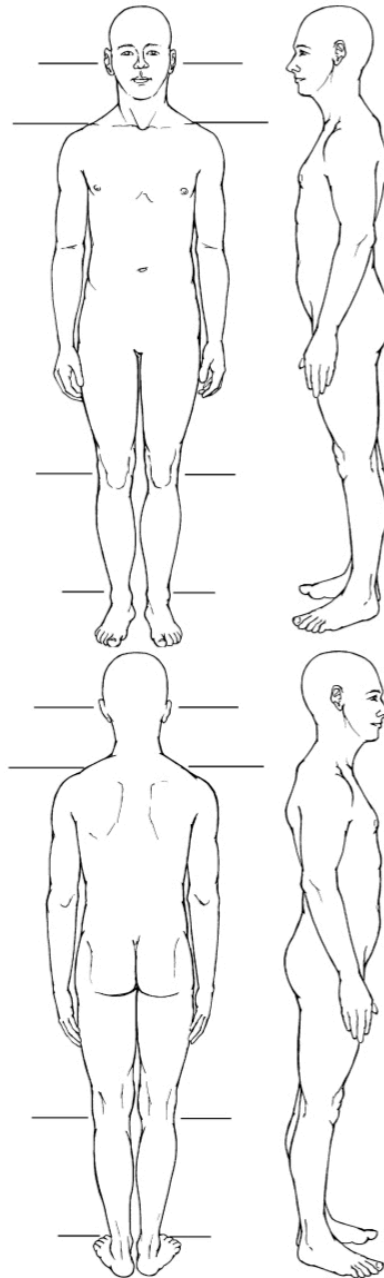
Response to Treatment (see Δ)

**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