Stoiber HealthCare SC

Personal Information

Name ______________________ Phone (day) ______________ (evening) ______________

- "By submitting your phone number, you are authorizing us (opting in) to send you text messages and notifications. Message/data rates apply. Reply STOP to unsubscribe to a message sent from us. No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All other categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties."

Address ______________________ City/State/Zip ______________________ DOB __________

Occupation ______________________ Employer ______________________

Email ______________________ Primary Physician ______________________

Emergency Contact ______________________ Relationship ______________ Phone ______________

How did you hear about us? ____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: ______________________

____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? ______________________

Any high risk factors? ______________________

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain ______________________

What makes it better? ______________________

____

What makes it worse? ______________________

____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: ______________________

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above:

____

____

____

____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other ______________________

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain ______________________

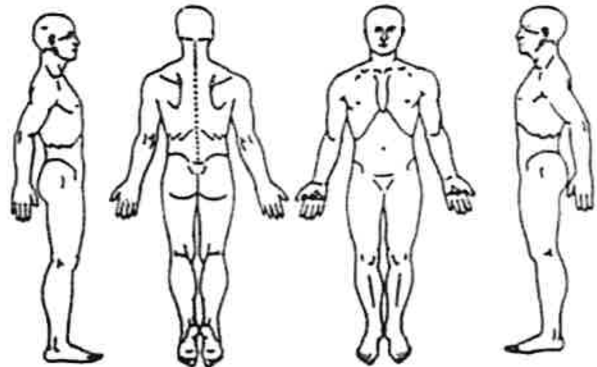
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain ______________________

What are your goals for this treatment session?

____

Please circle any areas of discomfort



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 Signature ______________________ *Date* __________

Therapist Signature ______________________ *Date* __________

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Massage Therapy Financial Policy

Cancellation & No Show Policy: We require at least 24 hours notice to cancel an appointment. Clients who cancel an appointment with less than 24 hours notice will be billed 50% of the price of the scheduled service. Clients who do not show up for a scheduled appointment will be charged for the 50% of the scheduled service. Exceptions for emergencies will be determined on an individual basis.

Late Arrival Policy: All scheduled appointments will end at the scheduled ending time in order for us to stay on schedule. Clients who arrive late to their scheduled appointment will be charged for the full session and will not receive a time extension. Please arrive 5 minutes before your scheduled appointment time to allow time to undress and get on the table to enjoy a relaxed and unhurried experience.

Payment: All payments must be made at the time of service. We take check, cash and credit card. Please write out all checks to Stoiber Healthcare, SC. Massage therapy services are not sent to your insurance; therefore it is your sole responsibility to pay for services at the time they are rendered.

Returned Checks: It is our policy to collect a fee of $35.00 for any check returned. This covers the bank fees that apply because of the transaction.

Financial Policy Questions: We are happy to address any questions or concerns regarding finances at any time during our business hours. Please direct financial questions to our billing department.

CLIENT/GUARDIAN SIGNATURE:________________________________

DATE: ____

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Massage Guidelines and Protocols

1. Massage sessions will begin and end at the scheduled time. Sessions that begin late due to the client's late arrival will end at the scheduled time and the client will be billed for the full time.
2. All clients will be treated with respect and dignity. Personal and professional boundaries will be respected at all times.
3. Clients must provide an accurate health history and agree to inform their therapist of any updates or changes to their health/medical condition.
4. Any client with a contagious condition including common cold, influenza, stomach flu, coronavirus, meningitis, shingles, contagious skin conditions, etc. must not come into the office, but call as soon as possible to inform the therapist before scheduled appointment time. Clients may reschedule their appointment after the contagious condition has resolved. Clients will not be charged for short notice cancellation
5. Clients with signs of symptoms of an active systemic or localized infection (e.g. fever, sore throat, swelling, etc.) at the time of a scheduled massage are asked to notify their therapist and reschedule their appointment. Clients will not be charged for short notice cancellation.
6. Massage therapists only provide therapeutic massage and modalities that are within the scope of practice for this licensed profession. Clients with acute injuries or conditions that are outside of the scope of practice for massage should consult with their doctor.
7. All clients will be appropriately draped with a sheet at all times during the massage session. Only the area(s) of the body that are currently being worked will be exposed. The genital area is never exposed or massaged.
8. Client privacy and confidentiality will be maintained at all times.
9. Any client who arrives under the influence of drugs or alcohol will be asked to leave.
10. This is a non-smoking, odor-neutral massage office.
11. Clients are expected to be clean and have showered prior to receiving massage (on same day).
12. All clients are provided with a competent and professional massage that focuses on the needs of each individual client.
13. Harassment of any kind is not tolerated and the session will be terminated if this occurs, or if the practitioner's safety is compromised in any way.
14. Clients are asked to avoid eating a heavy meal during the two hours prior to receiving massage.

I have read, fully understand and will abide by the massage guidelines and expectations listed above.

Sign: ______________________________ Date: ______________________________

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Massage Therapy Consent and Release Form

- I voluntarily request and consent to receiving massage therapy
- I understand that the massage service offered is for the purpose of general wellness, stress reduction, and relief of muscular tension only
- I do not have any injuries or conditions that prevent me from receiving massage therapy. I understand the importance of informing my massage therapist of all medical conditions and medications that I am taking, and that there may be additional risks based on my physical condition.
- If I experience any pain or discomfort, I will immediately inform my therapist so that the pressure or techniques used can be adjusted to my comfort level.
- I understand the risks associated with massage therapy include, but are not limited to:
    - Superficial bruising
    - Short-term muscle soreness
    - Exacerbation of undiscovered injury
- I do not have any contagious condition that may put my massage therapist or other clients at risk.
- I understand that I or the massage therapist may terminate the session at any time.
- I have been given the opportunity to ask questions about massage therapy and my questions have been answered.

I have been advised of the policies and procedures pertaining to massage and I understand these policies. Information regarding massage in general, benefits, contraindications of massage, and possible alternative therapies have been explained to me. I further understand that massage therapy is not a substitute for a medical examination or treatment, and that I should see a physician or other qualified health specialist for any mental or physical ailment of which I am aware. I understand that massage therapists do not diagnose illness or disease, and nothing said during the massage should be construed as such. My consent is informed and voluntary and I understand that I may withdraw my consent at any time except for actions already taken.

By signing this form I give my consent to proceed with the massage service as outlined above.

____

Client Name (Please Print)

__________/__________/__________

Date

____

Client Signature

Stoiber HealthCare SC

SOAP Note

Client Name ______________________

Session Type ______________________

Date of Service ______________________

Duration ______________________

S *Subjective information provided by client*

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O *Objective information and Modalities Applied*

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A *Assessment*

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P *Plan and recommendations*

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______________________ Therapist Signature

____/____/____ Date

Pain Adhesion

Hypertonicity Inflammation

Tender point Elevation

Trigger point Rotation