INTAKE FORM – CHAIR MASSAGE

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This form is intended solely to help ensure that the chair massage can be carried out safely and appropriately. Please provide only information relevant to the massage. If in doubt, we will discuss it before the massage.

PERSONAL DETAILS

Name: _____	**Date of birth:** ____ / ____ / _____
Chair massage date: ____ / ____ / _____	**First chair massage here?** ☐ **Yes** ☐ **No**

SHORT SAFETY CHECK

Tick what applies today. A 'yes' does not automatically mean that chair massage is not possible; we will first discuss whether an adjustment, postponement or medical advice is needed.

Question	Yes	No
Do you feel unwell today, have a fever or an active infection? ***Explanation:*** *For example, flu-like symptoms, fever, an active infection or feeling clearly unwell. It may be better to postpone the massage until you feel well again.*	☐	☐
Do you have an open wound, burn, skin infection or painful skin area in the massage area? ***Explanation:*** *This means damaged, irritated or infected skin in an area that may be touched during the chair massage. That area will not be massaged and the treatment may need to be adjusted.*	☐	☐
Do you have an acute injury, obvious swelling or inflammation, or recent trauma in the massage area? ***Explanation:*** *For example, a recent fall, bruise, strain, sprain, or sudden pain and swelling. We need to know whether certain pressure or movements should temporarily be avoided.*	☐	☐
Do you currently have thrombosis or a blood clot, have you had one recently, or is this being investigated? ***Explanation:*** *Thrombosis means that a blood clot is present in a blood vessel, often in a leg. If thrombosis is current, recent or suspected, chair massage will not be carried out without prior medical advice.*	☐	☐

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SHORT SAFETY CHECK – CONTINUED

Question	Yes	No
Have you recently had an operation or medical procedure that may be relevant to the massage? ***Explanation:*** *For example, surgery, stitches or another procedure where we need to consider healing, sensitivity or medical instructions. Only mention information that may affect the chair massage.*	☐	☐
Do you take blood-thinning medication, have a bleeding tendency, or bruise severely or easily? ***Explanation:*** *Blood-thinning medication can make bleeding or bruising more likely. This information allows the practitioner to adjust pressure and technique when appropriate.*	☐	☐
Are you pregnant? ***Explanation:*** *Pregnancy does not automatically exclude chair massage, but posture, support, pressure and technique can be adjusted for comfort and safety. It is therefore important to mention this in advance.*	☐	☐
Is there any other medical condition or treatment that may require an adjustment? ***Explanation:*** *For example, a condition, ongoing treatment or medical advice that may make certain positions, pressure or massage areas less suitable. You only need to provide information that is relevant to the chair massage.*	☐	☐

YOUR PREFERENCES

Areas to focus on: ☐ Neck ☐ Shoulders ☐ Upper back ☐ Arms/hands ☐ Other: _____
Explanation: *Tick where you mainly feel tension, stiffness or fatigue, or where you would like extra attention during this massage.*

Preferred pressure: ☐ Light ☐ Medium ☐ Firm ☐ Let the practitioner advise
Explanation: *Indicate what pressure feels comfortable. You can change this at any time during the massage; excessive pressure is never something you have to 'put up with'.*

Do not massage / please take extra care with:

_____
Explanation: *Note any area you would rather not have touched, a sensitive area, or anything practical the practitioner should take into account during the massage.*

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CONSENT

☐ I have completed the information above to the best of my knowledge. I understand that chair massage is a short massage performed over clothing while seated in an ergonomic massage chair and is not a substitute for medical diagnosis or treatment. I consent to the chair massage and will say immediately if anything feels uncomfortable or painful; the massage can always be adjusted or stopped.

Explanation: *By signing this statement, you confirm that you have shared relevant information and that you may say at any time during the massage what does or does not feel comfortable. You may withdraw your consent at any time.*

Client signature: _____	**Date:** ____ / ____ / _____

FOR PRACTITIONER USE ONLY

Intake notes / relevant details / agreed adjustments: