INTAKE FORM – CHAIR MASSAGE

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This form is intended solely to ensure that the chair massage can be performed 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

BRIEF SAFETY CHECK

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

Question	Yes	No
Do you feel unwell today, have a fever or an active infection?	☐	☐
Open wound, burn, skin infection or painful area in the massage area?	☐	☐
Acute injury, swelling/inflammation or recent trauma in the massage area?	☐	☐
Thrombosis/blood clot (current or recent), or is this being investigated?	☐	☐
Recent surgery or medical procedure that may be relevant to the massage?	☐	☐
Blood thinners, bleeding tendency or easily developing severe bruising?	☐	☐
Are you pregnant? ☐ N/A	☐	☐
Other medical condition or treatment that may require an adjustment?	☐	☐

YOUR PREFERENCES

Areas to focus on: ☐ Neck ☐ Shoulders ☐ Upper back ☐ Arms/hands ☐ Other: _____

Preferred pressure: ☐ Light ☐ Medium ☐ Firm ☐ Let the practitioner advise

Do not massage / please consider: _____

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 on an ergonomic massage chair and does not replace medical diagnosis or treatment. I consent to the chair massage and will immediately

indicate if anything feels uncomfortable or painful; the massage can always be adjusted or stopped.
Client signature: _____ | **Date:** ____ / ____ / _____

FOR THE MASSAGE PRACTITIONER ONLY

Notes / agreed adjustment:

_____