DAVE'S BARBERSHOP | CHAIR MASSAGE

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. Only fill in what is relevant to the massage. If in doubt, we will discuss this before the massage.

PERSONAL DETAILS

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

BRIEF SAFETY CHECK

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

Question	Yes	No
Do you feel ill today, do you have a fever or an active infection? ***Explanation:*** *For example, flu-like symptoms, fever, a contagious infection, or feeling clearly unwell. It may then be more sensible to postpone the massage until you feel well again.*	☐	☐
Do you have an open wound, burn, skin infection or painful area of skin in the massage area? ***Explanation:*** *By this we mean damaged, irritated or infected skin in areas that are touched during the chair massage. Such an area will not be massaged and may be a reason to adjust the treatment.*	☐	☐
Do you have an acute injury, obvious swelling/inflammation or recent trauma in the massage area? ***Explanation:*** *Think of a recent fall, bruise, strain, sprain, or sudden pain and swelling. We want to know whether certain pressure or movement should be temporarily avoided.*	☐	☐
Do you currently have, or have you recently had, thrombosis or a blood clot, or is this being investigated? ***Explanation:*** *Thrombosis means that there is a blood clot in a blood vessel, often in a leg. In the case of current, recent or suspected thrombosis, massage is not performed without prior consultation.*	☐	☐

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BRIEF SAFETY CHECK – CONTINUED

Question	Yes	No
Have you recently had surgery or a medical procedure that may be relevant to the massage? ***Explanation:*** *For example, surgery, stitches, or another procedure where we need to take recovery, sensitivity or medical instructions into account. Only mention what may affect the chair massage.*	☐	☐
Do you use blood-thinning medication, have a tendency to bleed, or develop significant bruising easily? ***Explanation:*** *Blood thinners can make you bleed or bruise more easily. With this information, the massage therapist can adjust the pressure and technique if necessary.*	☐	☐
Are you pregnant? ***Explanation:*** *Pregnancy does not automatically rule out 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 another medical condition or treatment that may require an adjustment? ***Explanation:*** *Think of a condition, ongoing treatment or medical advice that may make certain positions, pressure or massage areas less suitable. You only need to provide information relevant to the chair massage.*	☐	☐

YOUR PREFERENCES

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

Explanation: *Tick where you mainly experience tension, stiffness or fatigue, or where you would like extra attention during this massage.*

Preferred pressure: ☐ Light ☐ Medium ☐ Firm ☐ Let the massage therapist advise

Explanation: *Indicate which pressure feels comfortable. You may always change this during the massage; too much pressure never has to be 'part of it'.*

Do not massage / please take extra care with:

_____

Explanation: *Note here an area you would rather not have touched, a sensitive area or anything practical the massage therapist should take into account during the treatment.*

CONSENT

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

Explanation: *This confirms you shared relevant information, can speak up during the massage, and can withdraw consent.*

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

FOR THE MASSAGE THERAPIST ONLY

Notes / agreed adjustment: _____