Chair massage intake form

Seated massage over your clothes, with no oils.

YOUR THERAPIST

Name _____ **Privacy policy** _____

Business name and contact info _____

Your name _____ **Date** _____

Company or event _____

Before your massage

1	Are you feeling unwell today, or do you have a fever or an infection?	☐ Yes	☐ No
2	Have you had any surgery, injury or broken bones in the past three months?	☐ Yes	☐ No
3	Have you ever had a blood clot (such as DVT), or do you take blood thinners?	☐ Yes	☐ No
4	Are you pregnant, or have you given birth in the past three months?	☐ Yes	☐ No
5	**Only if you answered yes to 4:** have you had any complications, or has your doctor, OB or midwife advised against massage?	☐ Yes	☐ No
6	Do you have a medical condition, or take medication, that could be affected by a massage today? For example heart or blood pressure problems, epilepsy, diabetes, osteoporosis, cancer treatment or allergies (for example to latex).	☐ Yes	☐ No
7	Do you have any neck, back or shoulder problems (such as a pinched nerve, whiplash or a disc problem), or have you hit your head recently?	☐ Yes	☐ No
8	Do you have any skin conditions, rashes or broken skin on your head, neck, shoulders, back, arms or hands?	☐ Yes	☐ No

If you answered yes to any question, please tell your therapist more:

_____

_____

_____

9 Are there any areas to avoid, how much pressure you like, or anything else your therapist should know?

_____

_____

Your consent

I agree to receive a seated chair massage today. I have answered these questions honestly and will tell my therapist if anything changes. I understand that massage therapists don't diagnose illness or prescribe treatment, that this massage is not a replacement for medical care, that I stay fully clothed, and that I can ask to stop at any time.

Your therapist will keep this form securely for _____ years, as their state and insurer require, then destroy it.

Client signature _____ **Date** _____

If under 18, parent or guardian name and signature _____ **Date** _____

Therapist signature _____ **Date** _____

For the therapist: ☐ Massage given ☐ Modified ☐ Declined today ☐ Advised to see their doctor

Notes _____