

# Chair Massage Sign Up & Payment Sheet

Date of visit \_\_\_\_/\_\_\_\_/\_\_\_\_ Location \_\_\_\_\_

Name	Phone Number or Extension	Amt. Paid	Health Form Complete?
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1.			
2.			
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30.			

Administrator Name \_\_\_\_\_ Total Collected \$ \_\_\_\_\_

# Chair Massage Sign Up & Payment Sheet

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This form is designed to be used by the chair massage program administrator at the site where chair massage is taking place.

Please note the

- **Date** of the scheduled Chair massage visit, and
- The company name on the **Location** line.

There is room for

- **30 participants**
- Their **phone numbers or extensions** - in the case that they are late or forget their appointment, the therapist may use a nearby phone to call them and remind them.
- **Amount paid** to administrator for time slot, if applicable. If the employer is paying for the sessions, this column would be left blank.
- A **Health Form Complete** column where the administrator may mark off whether or not a health form has already been completed for each participant.

At the bottom of the form is a line for the **administrator's name**, and the total **money collected** from participants.

## **Chair Massage Client Information Form**

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This form is for use by chair massage participants, and provides basic health information to the chair massage therapist. Contact information is also requested so that we may follow up to clarify any questions, problems, or concerns, and invite participants to continue to use our services.

Please be sure participants fill this form out to the best of their knowledge. Therapists should clarify any key points and request further information as needed at the time of the massage session.

Please be as complete as possible, and fill in all information requested, so that we may provide the best possible service now and in the future!

Thank you!

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# Chair Massage Client Information Form

## Ishman BodyCare Center

www.ibodycare.com  
608 S. Washington Street  
Naperville, IL 60540

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_  
Home email \_\_\_\_\_  
Work email \_\_\_\_\_  
Site of Chair Massage \_\_\_\_\_  
Medication (s) \_\_\_\_\_

Medical concern (Please explain)

1. **Back - Neck** Now/Prior \_\_\_\_\_
2. **Cancer** Now/Prior \_\_\_\_\_
3. **Heart** Now/Prior \_\_\_\_\_
4. **Broken bones or fractures** Now/Prior \_\_\_\_\_
5. **Tension, stress, anxiety, depression** Now/Prior \_\_\_\_\_
6. **Overweight** Now/Prior    **Underweight** Now/Prior \_\_\_\_\_
7. **Skin problems** Now/Prior \_\_\_\_\_
8. **Other** Now/Prior \_\_\_\_\_

**Are you under the care of a physician?** Yes/No

(contacted only by permission)

Physician Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_

I understand that \_\_\_\_\_ does NOT diagnose or treat illnesses or injuries. I am solely responsible for my physical condition and for seeking medical treatment when I feel it is necessary for my well-being.

Please sign \_\_\_\_\_

Date \_\_\_\_\_

Therapist's Signature \_\_\_\_\_