NEW ENGLAND
Workplace Therapies
ON-SITE CHAIR MASSAGE

New England Workplace Therapies, LLC
PO Box 6413
Nashua, NH 03063
www.workplace-therapies.com

Seated Massage Client Intake Form

Name: ________________________ Company: ________________________

*For quarterly newsletter provide your EMAIL ADDRESS:*__________________________________

Have you received massage before? YES / NO (circle one)

If YES, what is your preference for pressure? Light / Firm / Deep (circle one)

What is your primary goal for this session? Relaxation____ Pain Relief_____

Are you currently experiencing any of the following? Check all that apply:

________	Tingling/Numbness	________	Recent Surgery	________	Fever
________	Carpal Tunnel	________	Recent Injury	_______	Nausea
________	Neck pain	________	Diabetic	________	Skin Rash
________	Back pain	________	Pregnant	________	Blood Clots
________	Pinched Nerve			________	Fainting Spells
________	Headaches				

Please inform the massage therapist if you are taking any medications or are under the care of a medical professional for a specific condition.

Massage may not be advised in some cases
Please consult your Primary Physician before receiving chair massage if you are pregnant, have a fever or contagious virus or skin condition, have asthma or faint easily. Your therapist may require a note from your Primary Physician before massage, based on the medical information provided above.

Informed Consent Agreement

- I have disclosed all my known physical conditions, and medications, and I will keep the massage therapist updated on any changes.
- I understand that massage therapy is not a substitute for medical treatment or medications. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.
- I understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, and improve circulation.
- If at any time during the massage *anything* feels uncomfortable, I will speak up so the pressure and technique can be adjusted to my needs.

I give my consent to receive treatment.

Signed:___________________________ Date:____________

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