THE ANNEX INC.
wellness & fitness center

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MASSAGE THERAPY SERVICES

WELCOME! I would like to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your session, please let me know.

Name_____ Date of birth _____

Address_____

City, State, Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Occupation_____ E-mail_____

Have you ever received massage therapy? ❑ Yes ❑ No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.)_____

Are you currently taking any medications? ❑ Yes ❑ No If yes, please list name and reason for medications:

_____

Are you currently seeing a healthcare professional? ❑ Yes ❑ No If yes, please list names and reason/treatment:

_____

Please review this list and check those conditions that have affected your health either recently or in the past.
Place a check mark next to the condition.

___arthritis	___depression, panic disorder, other psych	___diabetes	___condition
___blood clots	___diverticulitis	___broken/dislocated bones	___headaches
___bruise easily	___heart conditions	___cancer	___back problems
___chronic pain	___high blood pressure	___constipation/diarrhea	___insomnia
___auto-immune condition*	___muscle strain/sprain	___hepatitis (A, B, C, other)	___pregnancy
___skin conditions	___scoliosis	___stroke	___seizures
___surgery	___TMJ disorder	___TMJ disorder	___whiplash
___chemical dependency (alcohol, drugs)			

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so:

_____

_____

_____

_____

_____

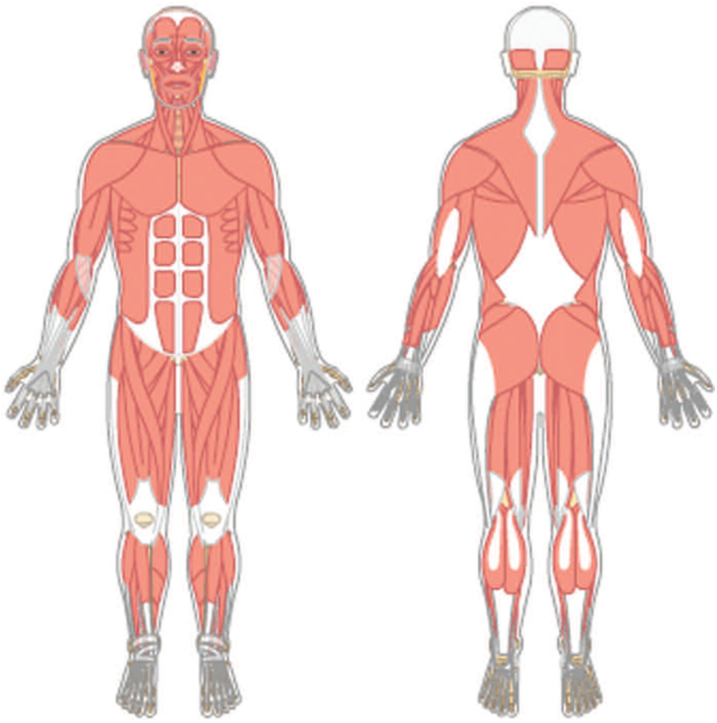
Do you have any allergies to:

_____medications foods (nuts, etc.) _____environmental allergens (dust, pollen, fragrances) _____reactions to skin care products

If any of the above are checked, please give details:

Are you wearing: _____contact lenses _____hearing aid/hairpiece

PLEASE INDICATE WITH AN (X), IF ANY, THE AREAS IN WHICH YOU ARE FEELING DISCOMFORT:



What are your goals/expectations for this treatment?

_____

_____

_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: need to move or change position • sighing, yawning, change in breathing • stomach gurgling • emotional feelings and/or expression movement of intestinal gas • energy shifts • falling asleep • memories

PLEASE READ THE FOLLOWING INFORMATION AND SIGN BELOW:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date: _____