The Lounge-Client History Form

Name: _____ Birth Date: _____

Address: _____ zipcode: _____

Phone number: (mobile) _____ (work) _____ (home) _____

Email address: _____ Referred by: _____

Occupation: _____ Hobbies: _____

Pregnant? Yes No If yes, how many weeks _____ Children? _____

What is your primary reason for receiving a massage? _____

Favorite areas to be massaged? _____

Have you had a professional massage before? Yes No If yes, what type of massage have you experienced? Swedish, Therapeutic, Deep, Stones, _____.

What kind of pressure do you prefer? Light Moderate Deep Trigger point

Are you right or left handed? _____ Are you allergic to nut products? _____

Emergency contact: _____ Phone#: _____
Relationship: _____
Physician: _____ Phone#: _____

Please indicate any conditions you may have currently or have had in the past:

Headaches____ Allergies____ Cancer____ Diabetes____ Easy Bruising____ Fibromyalgia_____
Heart Problem____ Varicose Veins____ High blood pressure____ Low Blood Pressure_____
Osteoporosis_____ Arthritis_____ Any other health conditions we should know about?_____
_____

Surgery/Injuries in last 2 years? _____

Current Medications: _____

I understand that this treatment is not a replacement for medical care and that no diagnosis will be made. I have informed the therapist of all my known medical conditions and will update my medical health form if changes occur. I will inform the therapist of any discomfort or pain during the session. There is ZERO tolerance on illicit or sexual behavior, comments, or actions. This will result in immediate termination of the treatment and responsibility for full payment. There will be a $20 cancellation fee for no show appointments or appointments cancelled in less than 12 hours.

_____ _____ _____
Print Name Signature Date