

Please bring completed form to your appointment

Today's Date _____ / _____ / _____

Please answer all questions completely and honestly – it allows us to give you the safest treatments with maximum results. All information is confidential.

Name (Ms. Mrs. Miss. Mr. Dr.) _____ DOB _____ / _____ / _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Occupation _____

Referred By _____

Have you previously experienced:

Massage Therapy Facials Body Treatments Waxing Nail Services

Is the main focus of your treatment today to address:

Mind: stress, restless thoughts, anxiety Body: beauty, chronic pain, injury

Spirit: relaxation, grounding, nurturing

Are you allergic to:

Sulpher Collagen Citrus Nuts Latex Shellfish Seaweed

Aspirin Honey/Bee Products Alpha Hydroxy Acids Iodine

Other _____

Please list skincare products and brands that you currently use:

Have you ever had an allergic reaction to a skincare product?

Yes No

Do you use Retin-A, Accutane or other prescription skin treatments?

Yes No (specify) _____

Do you experience any of the following:

- | | | | |
|---|-------------------------------------|------------------------------------|--------------------------------------|
| <input type="radio"/> Heart Disease | <input type="radio"/> Lyme Disease | <input type="radio"/> Gout | <input type="radio"/> Ovarian Cysts |
| <input type="radio"/> Recent Heart Attack | <input type="radio"/> Hepatitis | <input type="radio"/> Psoriasis | <input type="radio"/> Hysterectomy |
| <input type="radio"/> Pacemaker | <input type="radio"/> Renal Failure | <input type="radio"/> Eczema | <input type="radio"/> Post Menopause |
| <input type="radio"/> Cancer | <input type="radio"/> Fever | <input type="radio"/> Phlebitis | <input type="radio"/> Nail Fungus |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Epilepsy | <input type="radio"/> Thrombosis | <input type="radio"/> Plantar Warts |
| <input type="radio"/> Hyperthyroid | <input type="radio"/> Asthma | <input type="radio"/> Embolism | <input type="radio"/> Depression |
| <input type="radio"/> Hypothyroid | <input type="radio"/> Diabetes | <input type="radio"/> Lupus | <input type="radio"/> Claustrophobia |
| <input type="radio"/> Arthritis | <input type="radio"/> Rosacea | <input type="radio"/> Fibromyalgia | |

Any other medical conditions?

Do you take hormone replacement? Yes No

Oral contraceptives? Yes No

Are you currently pregnant? Yes No

Recent injury or surgery? Yes No

(specify) _____

Areas of chronic soreness or tension? _____

Please list all oral and topical medications and their actions: _____

Have you had cancers or other lesions removed? Yes No

Where from? _____

***Important – have you ever had cosmetic injections, plastic surgery, laser, etc?**

Yes No (specify) _____

I certify that all questions have been answered honestly and to the best of my ability. I understand that should the information above change, I should immediately inform the spa therapist for my own safety.

Client signature: _____