PARADISO DAY SPA

INTAKE FORM

Name:		Date:	Occupation:
Address:		Phone:	Date of Birth:
City:	State:	Zip Code:	Email:
Emergency Contact Name:			Phone:
How did you hear about us:			Referral Name:

GENERAL HEALTH ***If you provide us with your email address we will add you to our birthday & specials database**

1. Rate your level of stress: (5 = highest, 1= lowest) 5 4 3 2 1

2. Do you wear contact lenses? Yes No

3. Please list any allergies you may have:

4. Please list any medications you are currently taking:

MASSAGE THERAPY	GOAL FOR YOUR MASSAGE SESSION
Have you ever had a professional massage before? If so, when?	☐ Relaxation
What type of pressure do you prefer?	☐ Pain Relief
Is there any area of your body you do not want massaged?	☐ Stress reduction

HEALTH HISTORY

☐ Heart Condition	☐ Lymph Edema	☐ Herpes/Shingles	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Numbness/Tingling	☐ Sinus Problems	☐ Allergies	☐ Chronic Pain	☐ Varicose Veins
☐ Rashes	☐ Jaw Pain/TMJ	☐ Blood Clots	☐ Constipation	☐ Sprains/Strains
☐ Diabetes	☐ Gas/Bloating	☐ Headaches	☐ Arthritis	☐ Spasms/Cramps
☐ Broken/Fractured Bones	☐ Pregnancy (___ weeks)	☐ Fatigue/Sleep Disorder	☐ Depression/Anxiety	☐ Cancer
☐ Other (explain):				

SKIN CARE

1. Are you under the care of a dermatologist? ☐ Yes ☐ No

2. Do you use: ☐ Accutane ☐ Retin A ☐ Renova ☐ Adapalene ☐ Other prescription skin products

3. Have you had a: ☐ Chemical Peel ☐ Microdermabrasion ☐ Botox ☐ Other resurfacing treatments

4. Are you currently using any products that contain: ☐ Glycolic Acid ☐ Lactic Acid ☐ Hydroxy Acid ☐ Vitamin A

5. Do you have any skin sensitivities or irritants?

It is my choice to receive spa therapies. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update Paradiso Day Spa of any changes to my health status. I understand that Estheticians & Massage Therapists do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal manipulations. I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and that is recommended I see a primary health care provider for that service. If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24 hour notice, I agree to pay the missed appointment fee that may apply.

I understand that any illicit or sexually suggestive behavior, remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled service.

Signature:_____ Date:_____