Date__________________

The following questionnaire provides the information
that will enable us to provide you services & treatments safely & effectively. All information is completely confidential,
and vital for your protection as well as ours. Thank you for your cooperation.

First Name: ________________________ Middle: _________________ Last: ______________________________________

Address: ______________________________________ City: _______________________ State: _______ Zip: __________

Home Phone: _______________________ Cell Phone: ______________________ Work Phone: _______________________

Birthday: ______________________ Anniversary, if married: ______________________________________

Email: ___________________________________ Would you like to receive specials by email?_______________________

Occupation: ____ Referred By: ____

MEDICAL HISTORY:

Please list all medication you take Internally/Topically: ____

Do you have health problems? (Please check all that apply currently or in your past)

___ Allergies ___ Thyroid ___ Diabetes ___ High/low Blood Pressure

___ Cancer/Cancer Therapy ___ Headaches ___ Back/neck pain ___ Skin Conditions

___ HIV/Aids ___ Hepatitis ___ Pregnant/Lactating *NEED PRENATAL FORM*

___ Blood clots ___ Epilepsy ___ Metal Plates ___ Heart Problems/Pacemaker

Please explain any checked above: ____

Do you have any other Medical Conditions we need to be aware of? ____

Have you ever experienced an allergic reaction to any drug or other substance? (If yes, please explain): ___________________

SKIN CARE AND WAXING:

What skin care line are you using? _____________________ Do you wear makeup? ______ What brand? ________________

Please explain how you take care of your skin daily/nightly: ____

Have you ever had an allergic reaction to a cosmetic product? (If yes, please explain):_________________________________

Please circle the skin care products you are currently using at home:

Cleanser Vitamin C Toner Exfoliant/Scrubs Moisturizer SPF Mask

Please circle if you are using or have used any of the following:

Benzoyl Peroxide (BP) Glycolic Acid (AHA) Lactic Acid (AHA) Resorcinol Salicylic Acid (BHA)

Sulfur Vitamin C Vitamin A Hydrocortisone (HC) Hydroquinone

(OVER)

What skin conditions do you want to improve? (Please circle all that apply)

Acne and/or Breakouts   Rosacea   Facial Scarring   Uneven Tone   Hyperpigmentation (Freckles, Age Spots)

Enlarged Pores   Dehydration   Uneven Texture   Oily   Sun Damage

Fine Lines and Wrinkles   Other: ____

NAILS:

How often do you get nail services? _______________ What do you want out of the service? ______________________

Please circle if you have any of the following:

Athletes Foot   Warts   Foot/Nail Fungus   Ringworm   Hangnails

Are you allergic to Phameldahyde, Toleen, or Coleen? _____

Where are your problem areas? ____

MASSAGE THERAPY:

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to providing service.

Have you ever experienced a professional massage or bodywork session? ________ How recently? __________________

If yes, what did you like about it? __________________________ What didn't you like? __________________________

What type of pressure do you prefer? __________________________ *Deep Tissue is an additional fee*

Have you been in an accident or suffered any injuries? (If yes, please explain): ____________________________________

____

Do you have tingling or numbness in a specific area? (If yes, please explain): _____________________________________

Areas of the body to administer additional Massage Therapy: ____

Areas to be avoided: ________________________________ Reason: ____

Appropriate draping will be used at all times. At any point a guest is uncomfortable, they may request to stop the service.

I, the client, understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. In consideration of using the spa facilities and/or taking part in spa treatments/programs, I agree, to the fullest extent permitted by law, to forever release, indemnify, defend and hold harmless the spa, it's subsidiaries and affiliates, their respective agents, officers, directors, owners, contractors and employees (collectively the "Released Parties") from any and all claims and causes of action which I (or the below-mentioned minor) might otherwise have or be entitled to assert as a result of or related to any physical injury or otherwise, including without limitations to death pr property damage or loss sustained in connection with my use (or the below mentioned minor's use) of the spa facilities, or participation in any spa program or treatment, including, without limitation, claims and causes of action based on negligence, breach of warranty or breach of contract. I also agree to indemnify, defend, and hold harmless the Released Parties from any and all claims brought by the third parties arising out of any (or the below-mentioned minor's) acts, errors, or omissions.

Client Signature: ____

Consent to Treatment of Minor Under the Age of 17: By my signature below, I hereby authorize a Registered Licensed Massage Therapist to administer massage or bodywork therapy techniques to my child or dependent as they deem necessary.

Guardian Signature: ____