



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      Hyper-pigmentation (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? \_\_\_\_\_

**Relaxing Massage:**

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 Relaxing Massage? \_\_\_\_\_ How recently? \_\_\_\_\_

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

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 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: \_\_\_\_\_ Date: \_\_\_\_\_

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: \_\_\_\_\_ Date: \_\_\_\_\_