Skin Deep
DAY SPA
Beautiful You Inside and Out

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

1. Rate your level of stress: (5 = highest, 1= lowest) 5 4 3 2 1
2. List your stress or other stress reduction activities:
3. Do you wear contact lenses? Yes No
4. Do you smoke? Yes No How many cigarettes per day?
5. Please list any accidents/injuries, surgeries or hospitalizations in the last 9 months:
6. Do you have any metal implants, a pacemaker or body piercings?
7. List the medications you are currently taking:

Health History circle any that apply

Heart Condition	lymph Edema	Herpes/Shingles	High Blood Pressure	Low Blood Pressure
Numbness/Tingling	Sinus Problems	Allergies	Chronic Pain	Varicose Veins
aches	Jaw Pain/TMJ	Blood Clots	Constipation	Sprains/Strains
diabetes/inulin?	Gas/Bloating	Headaches/where	Arthritis	chest pain

Broken/Fractured Bones fatigue/Sleep Disorder

Depression/Anxiety Cancer allergic to any plant based products

Pregnant/ What week are you_____ Have you had any of the following bleeding cramping Amniotic fluid leaking swelling high blood pressure headaches considered high risk? Gestational diabetes twins or triplets Rh or genetic issues Chronic high blood pressure

Misc. Services

Have you ever had a detox foot bath? Detox Wrap?

Have you ever had ear candling done?

Massage Therapy

Have you ever had a professional massage before? If so, when?

What type of pressure do you prefer?

What is your goal for your massage session? please circle: Relaxation Pain relief Stress reduction

Have you had any joint replacement or serious injuries or surgeries?

Please explain:

Areas of discomfort

Skin Care and Waxing Service Circle any that apply

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

3. Have you had a: Chemical Peel Microdermabrasion Botox Dermaplaning 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?

Skin Maintenance

Skin Type:	Oily/Congested	Dry/Dehydrated	Sensitive/Redness	Acne	Sunburned
	Eczema	Claustrophobia	Psoriasis	Iodine or Shellfish	
Products You Use:	Soap	Cleanser	Toner	Moisturizer	Exfoliator Masque

Have you been tanning in the last 24 hours? Yes No

What are your skin care goals?

Spa treatments & Massages 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 Skin Deep Spa of any changes to my health status. I understand that 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. I understand that services such as Reiki and Aromatherapy are Holistic Therapies that are gentle hands on and energy based. 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 24hour notice, I agree to pay the missed appointment fee that applies. I understand that if I am late for my scheduled appointment, my service may be cut short to keep other clients on their scheduled times, and I will be charged the full amount of my service. 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.

I understand that gift cards are non-refundable and the Spa is not responsible for lost or stolen cards.
I understand also, that the only returnable products are Dermalogica, Jane Iredale and Jan Marini and in order to return them I must have the original receipt and return them within 30 days. It must also have at least half of the product left.

Date _____

Signature _____

(If client is under 18) Parental consent signature _____ Date _____