SKIN DEEP DAY SPA
1216 WILDWOOD, SUITE C
JACKSON, MI 49202

NAME:	**DATE:**	**OCCUPATION:**
ADDRESS:	**PHONE:**	**DATE OF BIRTH:**
CITY: **STATE:**	**ZIP CODE:**	**EMAIL:**
EMERGENCY CONTACT NAME:		**EMERGENCY PHONE:**
HOW DID YOU HEAR ABOUT US?		**REFERRAL NAME:**

GENERAL HEALTH

RATE YOUR STRESS LEVEL *(5 = HIGHEST, 1 = LOWEST)* **5 4 3 2 1**
DO YOU WEAR CONTACT LENSES? YES NO
HOW MANY OUNCES OF CAFFEINE DO YOU DRINK DAILY? **DO YOU SMOKE? YES NO HOW MANY CIGARETTES PER DAY?**
PLEASE LIST ANY ACCIDENTS/INJURIES, SURGERIES OR HOSPITALIZATIONS IN THE LAST 9 MONTHS:
DO YOU HAVE ANY METAL IMPLANTS, A PACEMAKER OR BODY PIERCINGS? IF YES, PLEASE LIST:
ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF YES, PLEASE LIST/EXPLAIN: **ARE YOU CURRENTLY UNDER MEDICAL CARE? IF YES, PLEASE EXPLAIN:** **IF YOU HAVE BEEN UNDER MEDICAL CARE, HOW LONG HAS IT BEEN SINCE YOUR LAST TREATMENT?**
PHYSICIAN/HEALTH CARE PROVIDER NAME:

HEALTH HISTORY – *PLEASE CIRCLE ANY THAT APPLY*

ALLERGIES
ARTHRITIS
BLOOD CLOTS
BROKEN/FRACTURED BONES
CANCER/WHEN _____
CHEST PAIN
CHRONIC PAIN
CONSTIPATION
DIABETES
DEPRESSION/ANXIETY
FATIGUE/SLEEP DISORDER
FREQUENT COLD SORES
GAS/BLOATING
HEADACHES/WHERE _____
HEART CONDITION
HEPATITIS
HERPES/SHINGLES/WHERE
HIGH BLOOD PRESSURE
LOW BLOOD PRESSURE
HIV/AIDS
JAW PAIN/TMJ
LYMPH EDEMA
NUMBNESS/TINGLING
SINUS PROBLEMS
SPRAINS/STRAINS
VARICOSE VEINS
ANY ACTIVE INFECTION _____
AUTO IMMUNE DISORDER _____
LUPUS
OTHER? PLEASE EXPLAIN:
_____
_____
N/A

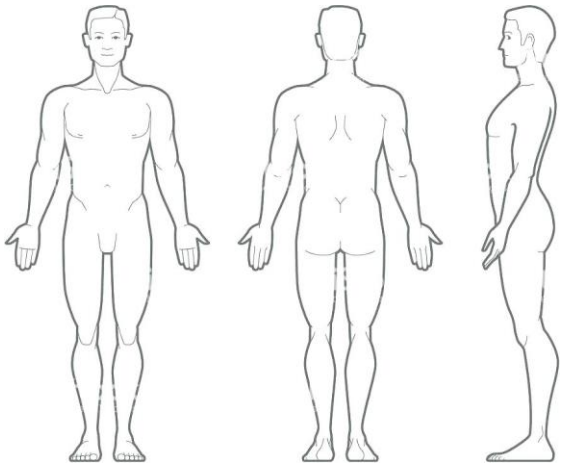
MASSAGE

HAVE YOU EVER RECEIVED A PROFESSIONAL MASSAGE/BODY WORK BEFORE? YES NO

HOW RECENTLY?

WHAT TYPE OF MASSAGE DO YOU PREFER, WHAT KIND OF PRESSURE DO YOU PREFER?_____

WHAT ARE YOU GOALS/EXPECTED OUTCOMES FOR RECEIVING MASSAGE?



HOW DO YOU FEEL TODAY?
LIST AND PRIORITIZE YOUR CURRENT SYMPTOMS/ISSUES *(STRESS, PAIN, STIFFNESS, NUMBNESS/TINGLING, SWELLING, ETC.) :*

DO THESE SYMPTOMS INTERFERE WITH OUR ACTIVITIES OF DAILY LIVING *(E.G. SLEEP, EXERCISE, WORK, CHILDCARE)* ***?***
EXPLAIN:

HAVE YOU HAD ANY INJURIES OR SURGERIES IN THE PAST THAT MAY INFLUENCE TODAY'S TREATMENT? ***EXPLAIN:***

AREA'S OF DISCOMFORT:
PLEASE DESCRIBE, AND "X" ANY AREAS ON THE DIAGRAM

LIST THE MEDICATIONS YOU CURRENTLY TAKE: N/A

_____

_____

CIRCLE ANY OF THE FOLLOWING HEALTH CONDITIONS THAT YOU CURRENTLY HAVE (*IF YOU ARE UNSURE, PLEASE ASK):*

BLOOD CLOTS	***INFECTIONS***	***CONGESTIVE HEART FAILURE***
CONTAGIOUS DISEASES	***PITTED EDEMA***	***N/A***

- ***PLEASE ANSWER HONESTLY, AS MASSAGE MAY NOT BE INDICATED FOR THE ABOVE CONDITIONS -***

PRENATAL MASSAGE

ARE YOU CURRENTLY PREGNANT? YES NO
HOW MANY WEEKS? _____

HAVE YOU HAD ANY OF THE FOLLOWING: ***PLEASE CIRCLE ANY THAT APPLY*** **–**		**N/A**
BLEEDING	**HIGH BLOOD PRESSURE**	**RH OR GENETIC ISSUES**
CRAMPING	**HEADACHES**	**CHRONIC HIGH BLOOD PRESSURE**
AMNIOTIC FLUID LEAKING	**GESTATIONAL DIABETES**	**CONSIDERED HIGH RISK?** ***EXPLAIN:***
SWELLING	**MULTIPLES**	_____

ARE YOU PLANNING ON BECOMING PREGNANT? YES NO
I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO LET MY THERAPIST KNOW BEFORE RECEIVING ANY TREATMENT IF I BECOME PREGNANT. X_____

SKINCARE & WAXING SERVICES

DO YOU USE: (*CIRCLE ANY OF THE FOLLOWING THAT APPLY)*		**N/A**	
ACCUTANE	**RETIN A**	**RENOVA**	**ADAPALENE**

OTHER RX SKIN PRODUCTS: _____

HAVE YOU HAD A: (*CIRCLE ANY OF THE FOLLOWING THAT APPLY)*
CHEMICAL PEEL MICRODERMABRASION BOTOX DERMAPLANING INJECTABLES
LASER TREATMENTS PLEASE LIST ANY RESURFACING TREATMENTS: _____

ARE YOU CURRENTLY USING PRODUCTS THAT CONTAIN: (*CIRCLE ANY OF THE FOLLOWING THAT APPLY)*
GLYCOLIC ACID LACTIC ACID HYDROXY ACID VITAMIN A BENZOYL PEROXIDE

DO YOU HAVE ANY SKIN SENSITIVITIES, ALLERGIES, OR IRRITANTS? *IF YES, PLEASE EXPLAIN:* N/A

_____

DO YOU HAVE ANY ALLERGIES TO: (*CIRCLE ANY OF THE FOLLOWING THAT APPLY)*
IODINE SHELLFISH ASPIRIN N/A

SKIN TYPE: (*CIRCLE ANY OF THE FOLLOWING THAT APPLY)*
OILY/CONGESTED DRY/DEHYDRATED SENSITIVE ROSACEA ACNE
SUNBURNED

SKIN CONDITIONS: (*CIRCLE ANY OF THE FOLLOWING THAT APPLY)* N/A
ECZEMA/WHERE _____ PSORIASIS/WHERE_____ CLAUSTROPHOBIA

PRODUCTS YOU USE: (*CIRCLE ANY OF THE FOLLOWING THAT APPLY)*
SOAP CLEANSER TONER SERUM MOISTURIZER SPF
MASQUE EXFOLIATOR

WHAT ARE YOUR SKINCARE GOALS? *EXPLAIN:* _____

HAVE YOU BEEN TANNING IN THE LAST 24 HOURS?	**YES**	**NO**
DO YOU HAVE EYELASH EXTENSIONS?	**YES**	**NO**
DO YOU WEAR CONTACT LENSES?	**YES**	**NO**

It is my choice to receive spa treatments, including massage, skin care, and hair removal. Because massage/body work, skin care and other spa treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, or answered all questions asked of me honestly. I will update Skin Deep Day Spa of any changes to my health status. I understand that estheticians and massage therapists do not diagnose illness, disease, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal manipulations or skeletal adjustments and that nothing said in the course of the session given should be construed as such. I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and this it is recommended I see a primary health care provider for that service. If I experience any pain or discomfort during the session, I will immediately inform the massage therapist and/or esthetician so that the service may be adjusted to my level of comfort or discontinued. I could experience varying degrees of redness, burning, peeling, and itching, etc., especially in the initial stages of a skin care program. I further understand that I am paying for a treatment and not a result of, that there will be no returns, refunds or exchanges.

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 my scheduled appointment without giving 24 hour notice, I agree to pay the missed appointment fee of 50% of the missed 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. Further, I understand that Skin Deep Day Spa reserves the right to refuse to administer services at their sole discretion. I have read and fully understand this form in its entirety. I hereby release the practitioners, Skin Deep Day Spa and their insurers, employees from all lability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving massage, skin care, and hair removal services.

***SIGNATURE:* _____ *DATE:* _____**

(*IF CLIENT IS UNDER 18)* PARENTAL CONSENT SIGNATURE: _____