** Intake Form**

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| Name: |  | Date: | Occupation: |
| Address: |  | Phone: | Date of Birth: |
| City: | State: | Zip Code: | Email: |
| Can we send you promotion emails and/or texts? | Yes No |  | Cell Provider: |
| 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 or surgeries 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: | | |  |
| **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? | | | |
| **Skin Maintenance** | | | |
| Products You Use: Soap Cleanser Toner Moisturizer Exfoliator Masque | | | |
| Skin Type: Oily/Congested Dry/Dehydrated Sensitive/Redness Acne Sunburned | | | |
| Eczema Claustrophobia Psoriasis Iodine or Shellfish | | | |
| Have you been tanning in the last 24 hours? Yes No | | | |
| What are your skin care goals? | | | |

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 Piel Bella Day Spa of any changes to my health status. I understand that Aestheticians, Massage Therapists and Manicurists 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 applies.

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.

Client Name Date

Therapist Name Date