Name ______________________ Birthdate ______________________ Age ________
Address ______________________ City ______________ State ______ Zip ________
Home Phone ______________________ Cell ______________ Work ______________
Profession ______________________ Employer ______________________
E-Mail Address ____

(Please write in all CAPITAL LETTERs and DIFFERENTIATE the letters i from L, and the letter L from the number 1)

What is the reason for your visit today? ______________ First facial / massage / wax? ______________
What special areas of concern do you have / areas of pain or tension? ______________________

____

Previous experience with spa treatments: ______________________________

____

Please check the question if the answer is YES:

- Within the past year, have you been under a physician's care?
- Within the past year, have you been under a dermatologists care?
- Within the last nine months have you undergone surgery? If so, please specify: ______________

List any medications, supplements & vitamins that you take regularly: ______________

____

List any allergies that you have: ______________________________
List Facial & body Products you currently use: ______________________________

Check if your answer is YES:

- Smoke
- Exercise regularly
- Follow a restricted diet
- Burn easily in moderate sunlight
- Pregnant or Nursing (Please circle)
- Birth control pills
- Hormone replacement
- Accutane, Retin-A, Retinoids or Renova
- Claustrophobic
- Wear contact lenses
- Metal implants or Pace maker
- Blush easily when nervous

Please mark (#) for the pain for the conditions that apply now and put a (P) for past conditions
Pain Scale: minor – 1 2 3 4 5 6 7 8 9 severe – 10

_____headaches, migraines
_____vision problems
_____hearing problems, deafness
_____injuries to face or head
_____sinus problems
_____dental bridges, braces
_____jaw pain, TMJ problems
_____asthma or lung conditions
_____abdominal, digestive problems
_____constipation, diarrhea
_____hernia
_____other medical conditions not listed
_____chronic pain
_____muscle or joint pain
_____muscle, bone injuries
_____numbness or tingling
_____sprains, strains
_____arthritis, tendonitis
_____autoimmune condition
_____cancer, tumors
_____spinal column disorders
_____heart, circulatory problems
_____high/low blood pressure
_____blood clots
_____fever
_____cold sores
_____diabetes
_____fatigue
_____tension, stress
_____depression
_____sleep difficulties
_____rashes, athletes foot
_____infectious diseases
_____systematic disease
_____varicose veins

Explain any areas noted above: ______________________________

____

Check any past treatments received:

- Acid Peels
- Laser injection
- Microdermabrasion
- Dermabrasion
- Collagen injections

When was your last Facial?______________
What results do you want to see from your skin care?______________________

Do you ever experience these skin conditions? Check if answer is YES:

- Flakiness
- Tightness
- Obvious dryness
- Oiliness
- Acne

Type of Massage You Prefer:

- Swedish
- Deep Tissue Work
- Reflexology
- Hot Stone
- Shiatsu

When was your last Massage?______________
Any difficulty lying on your back, front or turning?______________________

I understand that the services offered are not a substitute for medical care, and any information provided by the therapist is for educational purpose only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential. In order to maximize the effectiveness and safety of the sessions together, please participate in exchanging feedback prior, during and at the end of the session. This will help in tailoring the therapeutic session to serve your needs in the best possible way.

Massage, facials, body treatments, waxing and nail and foot treatments may be dangerous under certain conditions. In consideration of the fee charged, and paid by me and to the fullest extent permitted by the law, I hereby release Denise Hand owner of Hand's Face & Body, and as applicable her employees, contractors and subcontractors and agree to hold her and them harmless from any and all liability, claims, damages, actions, and causes of action whatsoever, for loss, damage or injury to person or property, irrespective of how arising and however caused. This includes but is not limited to all kinds and degrees or extent of negligence (expect willful or wanton negligence or misconduct), which the therapist may commit or be charged with in connection, directly or indirectly with the use of spa equipment and facilities and related activities.

If you have heart disease, hypertension (high blood pressure); if you are pregnant; if you have been advised by your physician to limit your physical activities in any way; or, if you have any medical conditions, allergy injury or illness which may be affected by use of the spa facility or services; you must notify the therapist prior to engaging in any spa service.

By signing this document, you are certifying that such disclosure has been made and agreement to of release of liability.

We have a 24-hour cancellation policy. We require 24 hours notice of cancellation for all of our appointments or you may be charged a cancellation fee of $20. We value your time – Please value ours.

Client Signature: ______________________________ Date: ____________________

Therapist Signature: ______________________________ Date: ____________________