Hand's FACE&BODY

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

Name _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Profession _____ Employer _____

E-Mail Address _____

Check 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 you have: _____

List facial and body products you currently use: _____

Check if the 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 pacemaker
- ☐ Blush easily when nervous

Please mark a number from the pain scale 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 ☐ Lase 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? _____

FOR LASHES CLIENTS ONLY — Additional Questions

Please Note: If you have had any of the following this may compromise your ability to successfully wear eyelash extensions. Please Circle Yes or No and add details where indicated.

Cancer: Yes / No

Contacts: Yes / No

Alopecia (Hair Loss): Yes / No

Demodex Folliculorum: Yes / No

Non-functioning tear ducts: Yes / No

Lasik surgery: Yes / No Date: _____

Permanent Make-up: Yes / No Last treatment: _____

Eye-Lift Yes / No Date:_____

Micro-dermabrasion / Chemical Peel: Yes / No Date: _____

Retin-A, Accutane & Acne medications: Yes / No Date of Last treatment: _____

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

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date