SHANTI Wellness Day Spa INTAKE FORM

Name: Date:	Occupation:
Address:	Date of Birth:
City: State: Zip Code:	Email:
Emergency Contact Name:	Phone (HM): (WK):
How did you hear about us:	Cell #:

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 2 years:
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 SHANTI Wellness Day Spa of any changes to my health status. I understand that the Aestheticians, Massage Therapists and Nail Technicians 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 it is recommended that 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 4 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 a 4-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.

Please use this space to give us any other information that you feel is necessary for your treatment.

Name_____**Date**_____

Consent to Treatment of Minor:

By my signature below, I hereby authorize Shanti Wellness Day Spa to administer massage, bodywork, skin care treatments and nail treatments to my child as they deem necessary.

Parent Guardian_____**Date**_____