LUXE Spa Client Information Form

Client Name _____ Date _____

Client Address _____

City _____ State _____ Zip _____

Email Address _____

Telephone: Home_____ Cell _____ Work _____

Birthday _____ under 18 18-30 31-40 41-50 51-60 60+
Month Day Year

Occupation _____ How did you hear about us? _____

What treatment are you having today? _____ Have you had this treatment before? Y N Frequency? _____

What is your reason for today's treatment? _____

What is your desired result for today's treatment? _____

CURRENT HEALTH

Have you had any health problems in the past or present including but not limited to the following:
AIDS/ARC/HIV Arthritis Asthma Cancer Constipation Dermatitis Epilepsy Fractures Fungal Infections
Headaches/Migraines Heart Disorders Herpes High/Low blood pressure Insomnia Phlebitis Psoriasis Stiff Neck Varicose Veins Warts Whiplash Diabetic Claustrophobic Pregnancy (current)_____weeks OR (postpartum) _____weeks

Do you have any known allergies?_____

Please list any current medications (OTC & Rx), supplements, vitamins, diuretics, slimming tablets, etc that you take regularly
_____

Have you had ANY surgeries, accidents or major illness? Yes No If so, please list dates & treatment received:
Surgeries _____
Accidents_____
Major Illness _____

MASSAGE

Location of pain/tension _____
How long have you had this pain/tension _____ Any actions to resolve the pain?_____
Activity that causes/increases pain _____
Are you under any medical supervision for this condition? Yes No If so, When? _____
Rate your level of stress on a scale of 1 to 4 (1 = low stress, 4 = high stress) 1 2 3 4
What type of massage pressure do you prefer? Light Medium Firm Deep
Are you uncomfortable receiving massage on any of the following areas?
Gluteal Region ___ Pectoral Region___ Abdomen ___Facial Scalp___ Feet ___
Please list any areas to avoid for any reason such as injury, skin conditions, ticklishness, self-consciousness etc.
_____

SKINCARE

How does your skin feel in the Morning? _____ Afternoon?_____Evening? _____
What skin care products are you currently using?
Face: Soap Cleanser Toner Moisturizer Mask Exfoliator Eye products
Body: Soap Shower Gel/Cream Scrub Oil Body Moisturizer Depilatories Self Tanners

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? Yes No
When? _____

Do you currently use Accutane; Retin A, Renova, Adapalene or any other prescription skin products? Yes No In the last 3 Months? Yes No

SEE REVERSE

Are you currently using any products that contain the following ingredients?
Glycolic Acid Lactic Acid Any Exfoliating Scrubs Any Hydroxy Acid Product Vitamin A Hydroquinone

Do you have a tendency to redness? Yes No
Do you ever experience oily shine during the day? Yes No Occasionally
Do you ever experience skin breakouts? Yes No Occasionally
Do you ever experience these conditions on your skin? Flakiness Tightness Obvious Dryness
Do you ever experience a burning, itching sensation on your skin? Yes No

Date

Therapist Remarks

Recommendations

Consent for Care- Please take moment to carefully read the following information and sign where indicated

I understand that if a specific medical condition or specific symptoms, massage/bodywork/skin treatment may be contraindicated. I understand that a referral from my primary care provider may be required prior to service being provided. I understand that the massage/bodywork/skin treatment I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and /or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork/skin treatment, should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork/skin therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so. Privacy for undressing/dressing will be assured. Removal of clothing to your comfort level is recommended. Proper draping will be provided to assure security and privacy. Only the body part being treated will be undraped, leaving the remainder of the body fully draped at all times. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Promptness is required for appointment times. In the event of lateness, the massage may be cut short. Fees may be maintained as per the schedule.

Client Signature _____ Date _____
Therapist Signature _____ Date _____