# Service Intake Form

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Telephone _____ Mobile Phone _____
Email Address _____ Birthday _____
Occupation _____ Employer _____
In Case of Emergency Contact _____ phone _____ Relationship _____

How did you hear about us? _____ *Referral if* so, who? _____
What are your specific concerns today? _____
How long have you been experiencing this discomfort? _____
What do you feel caused this? _____
What have you done to try and relieve this so far? _____
Did any of this help to relieve your discomfort or pain? _____
Do you exercise regularly? YES NO If so, what type of activities do you do and how frequently.

_____
Have you ever had a professional massage? YES NO When? _____
Have you ever had a professional facial? YES NO When? _____
Do you have any implanted medical devices containing electricity or metal? _____
Have you had surgery? If yes, please explain. YES NO _____
_____ When? _____
Have you had any adverse lasting effects from the above surgery? _____
What hair removal methods have you used in the last 6 weeks. _____
Do you currently have any skin lesions or sores? YES NO Where? _____
Have you ever had a nail infection or fungus? YES NO _____
Do you have an allergy to peanuts or peanut oil? YES NO
Do you have sensitivity to any plant based products? YES NO Please Explain _____

_____

**Have you ever had an allergic reaction to any of the following? (circle all that apply)**

| | | | | | |
|---|---|---|---|---|---|
| Cosmetics | Medicine | Food | Cinnamon | AHA's | Iodine |
| Nut and Nut Oils | Sunscreens | Fragrance | Fruits/Vegetables | Shellfish | Plants/Flowers |
| Pollen | Other _____ | | | | |

Explain _____
Are you exposed to the sun on a daily basis or are you planning to spend time in the sun soon? YES NO
Do you use a tanning bed? YES NO If yes, when was the last time. _____
List any medications that you are taking and the conditions that they are prescribed for: _____

_____
Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past 48-72 hours? YES NO
Are you using Retin-A, Renova, Accutane or other Acne medication? YES NO
Are you using any other skin thinning products or medications? YES NO Explain _____
Do you have arthritis? If yes, what areas are affected? _____
Do you have high blood pressure? YES NO Are you Diabetic? YES NO
Do you have any known spinal problems? YES NO Explain _____

**Continue on back**

Have you had any recent injuries that I need to be aware of? YES NO
Please explain _____
Are you currently under care of another health care practitioner for this or any other condition? YES NO
Dr. Name_____ Specialty _____Condition _____

**Are you experiencing any of the following? (Circle all that apply)**

| | | |
|---|---|---|
| Leg Cramps | Nausea | Irregular Bleeding |
| Hip Pain | Swelling/Edema | Acid Reflux |
| Headaches | Dizziness | Loss of Feeling/Tingling |

**What skin care products are you currently using? (Specify brand where known)**

Soap _____ Shower Gels _____
Toner _____ Body Lotions _____
Mask _____ Sunscreen _____
Eye Product _____ SPF _____
Cleanser _____ Night/Moisturizer Cream _____
Day Moisturizer _____ Other _____
Exfoliator _____ Makeup Products _____
Scrub _____ Lip _____

**What areas of concern do you have regarding your skin (circle all that apply)**

| | | | |
|---|---|---|---|
| Breakouts/Acne | Uneven Skin Tone | Dull Dry Skin | Blackheads/Whiteheads |
| Sun Damage | Dehydrated Skin | Excessive Oil | Wrinkles/Fine Lines |
| Flakey Skin | Rosacea | Broken Capillaries | Redness/Ruddiness |

Sun Spot/Liver Spot/Brown Spot Other _____

**EYES**

Dehydrated Wrinkles Puffiness Dark Circles Other _____

**LIPS**

Dehydrated Chapped/Cracked Lips Other _____

## For Women Only

Are you pregnant? YES NO Due date? _____ Weeks Along _____
Are you having any complications with your pregnancy? YES NO If yes, please explain.
_____
Is this your first pregnancy? YES NO If no, what number is this? _____
Have you ever had a miscarriage? _____ If so, when? _____
Were you able to determine the cause of the miscarriage? Explain _____
Are you currently breastfeeding? YES NO

I certify that all of the information provided is true and correct.
Signature of Client _____Date _____
Signature of Parent/Guardian _____Date _____
(If client under 18)

# Client Agreement and Spa Etiquette

## Payment Policies

- Payment is due in full at time of service.
- We accept Cash, Check, Visa, MasterCard, Discover, and American Express, Spa Finder and Spa Wish.
- A $25.00 fee will be charged for any returned check.
- Upon request, we can issue a receipt for you to submit for reimbursement from your insurance company. However, all claim submission and contact with the insurance company will be done through the patient as we are not an insurance provider.
- If you are unable to make your scheduled appointment please provide 24 hours notice of cancellation. Failure to provide 24 hour notice may result in a fee of 50% of your scheduled appointment charge.
- All appointments require a credit card number to confirm your reservation.
- Any promotional flyers, coupons or gift certificates must be surrendered at time of service in order to receive credit.
- No Children are permitted in spa unless receiving services.

**Treatment Purpose**

I understand that spa services are for the purpose of relaxation, stress reduction, relief from muscular tension or spasm and for increasing circulation and energy flow as well as to promote healthy skin, nails and body care. I understand that the Technicians do not diagnose illness, disease or any other physical or mental disorder. As such, the Technicians do not prescribe medical treatment or pharmaceuticals nor is any spinal adjustment performed. I understand that the Technician may need to refer me to my physician for my safety. I certify that all the information provided is true and correct. **Initial** _____

**Your Behavior**

I understand that illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and that I will be liable for payment of the scheduled appointment. Following such instance, I understand that I will not be permitted to receive any further treatments. If at any time during the session, your technician is uncomfortable, the session will also be terminated. By signing this form I agree to comply with the above terms. **Initial** _____

**Consent to Treat**

I have read the above information and if I have any concerns, I will address these with my technician. I give permission to perform the procedure discussed and I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my technician will take every precaution to minimize or eliminate negative reactions as much as possible. I am willing to follow recommendation made by my technician for a home care regimen that can greatly increase my results. In the event that I have any additional questions or concerns regarding my treatment or suggested home product/Post-treatment care, I will consult the technician immediately. I agree that this constitutes full disclosure and that it superseded any previous verbal or written disclosures. I do not hold A Premier Massage & Day Spa or the technician responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment today. I understand that if any of my information provided on this form changes it is my responsibility to notify my technician at the time of service. By Signing this form, I understand and will comply with the above terms.

Signature of Client _____Date_____

Signature of Parent or Guardian _____Date_____
(If Client under 18)