

# Absolute Necessities Day Spa

## Profile for all Spa Treatments

### CONTACT INFORMATION (Please Print)

Name:	Today's Date:	
Address:	Date of Birth:	
City:	State:	Zip code:
How would you like to be notified of your appointments? (one or both) <input type="checkbox"/> Email <input type="checkbox"/> Text Message	Home Phone: (     ) Cell Phone: (     )	
Email:	Occupation:	
Emergency Contact Name and Phone:		
How did you hear about us?		

### GENERAL HEALTH

List any medications you are currently taking: <input type="checkbox"/> antihistamines <input type="checkbox"/> antibiotics <input type="checkbox"/> birth control <input type="checkbox"/> any other:	
Do you have Arthritis? Where?	
Please list any accidents or surgeries in the last 5 years:	
Do you have any allergies?	Glasses of water per day?
Have you ever had massage therapy before? Yes / No When was your last one?	
Rate your level of stress: (5 = highest, 1 = lowest)    5    4    3    2    1	

### HEALTH HISTORY

<input type="checkbox"/> Smoker	<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Migraines
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Asthma/Emphysema	<input type="checkbox"/> Diabetic
<input type="checkbox"/> Dentures	<input type="checkbox"/> Spinal Problems	<input type="checkbox"/> Metal Pins/Plates	<input type="checkbox"/> Tremors, Seizures, Strokes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Cortisone Shot	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Hormone Replacement Therapy	
<input type="checkbox"/> Calluses	<input type="checkbox"/> Muscle Relaxers	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Pregnant? Months? _____	<input type="checkbox"/> Breastfeeding
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Infectious Diseases: Hepatitis, Tuberculosis, HIV, AIDS, MRSA, etc.		
<input type="checkbox"/> Foot Warts	<input type="checkbox"/> Athlete's foot	<input type="checkbox"/> Others (explain)		

### SKIN CARE

Are you under the care of a dermatologist? Yes No
Do you use: <input type="checkbox"/> Accutane <input type="checkbox"/> Retin A <input type="checkbox"/> Renova <input type="checkbox"/> Other Prescription skin products: _____
Are you currently using any products that contain: <input type="checkbox"/> Alpha or Beta Hydroxy Acid (Glycolic, Lactic, Salicylic Acid) <input type="checkbox"/> Vitamin A <input type="checkbox"/> Benzoyl Peroxide
Do you have any skin sensitivities or adverse reactions to waxing?

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**DO NOT USE** RetinA, Renova, or AHA products for 48 hours before and after waxing!

**DO NOT EXPOSE** skin to the sun or indoor tanning for at least 48 hours before or after peels or a waxing service!

I have answered all questions on this form correctly and to the best of my knowledge. The Massage Therapy given here is for the purpose of stress reduction, relief from muscular tension or for increasing circulation and energy flow. We do not diagnose illness or any other physical or mental conditions or prescribe treatments. We do not perform spinal manipulations. We are not a substitute for medical examinations.

I have stated all known medical conditions and take it upon myself to update my physical health to all Service Providers of the medical conditions and/or medication. My Service Provider is not responsible for any trauma or reactions that I may experience from the following services the Spa provides: Massage, Facials, Peels, Body Treatments, Compression Wraps, Waxing and Nail Services.

**Please give at least 24 hours notice if you cannot keep your appointment.  
If you do not make your appt, your service provider does not get paid.  
So please call us.**

*We are not responsible for lost or stolen items.*

**I have re-read and reviewed the above information; it is both accurate and current.  
I have corrected any outdated information.**

**Please sign one of the lines below:**

(If client is under 18, a parent or guardian signature is required instead of own.)

_____	_____
(Name)	(Date)
_____	_____
(Name)	(Date)
_____	_____
(Name)	(Date)
_____	_____
(Name)	(Date)
_____	_____
(Name)	(Date)