Client Care Information

Name:_____

Mailing Address: _____
Street (or PO Box) City State Zip

Phone: _____ Cell: _____

Email (please print clearly): _____
Would you like to be included on our email mailing list? _____ Yes ____ No

Birthday: _____ (MM/DD/YYY) Profession: _____

How did you hear about us? ___ Client ___ Email ___ Postcard ___Website ___ SPA Finder ___ City Search
___ Advertisement (where?) _____ _____ Walked By _____Other: _____
If referred by a client, please provide first and last name of referral._____
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Rate your general health: ____Excellent ___ Good ___ Fair ___ Poor

Are you pregnant? _____ If yes, due date: _____ Is your pregnancy considered high risk? _____

Do you have any special skin problems pertaining to your face or body? ____Yes _____ No
If yes, please specify _____

Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? ___ Yes ___ No

Do you suffer from sinus problems? ___ Yes ___ No
Please list any allergies: _____
Have you ever seen a specialist for nail infection or fungus? ____Yes____No If yes, when:_____
Do you wear: ___ Contacts ___ Dentures ___ Prosthesis Other: _____

Please check any conditions you have:

□ Allergies	□ Arthritis	□ Blood Clots
□ Carpal Tunnel Syndrome	□ Circulatory Problem	□ Contagious Disease
□ Diabetes	□ Heart Disease	□ High Blood Pressure
□ Joint Problems	□ Low Blood Pressure	□ Muscular Injuries
□ Respiratory Problems	□ Skeletal Injuries	□ Skin Problems
□ Spinal Problems	□ Varicose Veins	□ Other _____

Please be advised that if any contagious disease is noticed or suspected, services will stop at that moment and it will be explained to you that you need to see a Dr. This may be an uncomfortable conversation for both parties, however, please remember, we have your best interests at heart. I have stated all of my known medical conditions and take it upon myself to keep Tranquility updated on my physical health.

Please sign: _____ Date: _____

Skin Care

Your Name _____

What skin care products do you currently use?

Face: ___ soap ___ cleanser ___ toner ___ moisturizer ___ masque ___ exfoliator ___ eye products

Body: ___ soap ___ shower gel ___ scrubs ___ oil ___ body moisturizer ___ depilatory products ___ self tanner

Have you ever had chemical peels, microdermabrasion or any resurfacing treatments? ___Yes ___No

Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? ___ Yes ___ No

Are you currently using any products that contain the following ingredients?

___ glycolic acid ___ tactic acid ___ exfoliating scrubs ___ hydroxy acid products ___Vitamin A derivatives (i.e. retinol)

Do you experience skin breakouts? ___ Yes ___No ___ occasionally

If yes, where are the breakouts located? ___hairline ___forehead ___ under eye ___chin ___ cheeks ___ jaw line

Do you experience oily shine during the day? ____ Yes ____No ___ occasionally

Do you blush easily when nervous? ___ Yes ___No

Do you have a tendency to redness? ___ Yes ___ No

Do you suffer from sinus problems? ___ Yes ___ No

Do you experience a burning, itching sensation on your skin? ___ Yes ___No

Have you ever had a reaction to any of the following?

___ cosmetics ___ medicine ___ iodine ___ pollen ___ food ___ hydroxy acids ___ animals ___ fragrance

___ sunscreens ___Other _____

Do you ever experience these conditions on your skin? ___ flakiness ___ tightness ___ obvious dryness

How much plain water do you consume daily? _____

Are you pregnant? _____ If yes, due date: _____ Is your pregnancy considered high risk? _____

Estheticians are licensed professionals whose primary concern is to provide superior care for their patrons. Through education and training they are on the look-out for any potential health concerns, such as a suspicious mole, an unexplained skin rash or nail fungus. Since they are not doctors and cannot diagnose, they can only state their concerns and recommend the advice of a physician.

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Please sign: _____ Date: _____

Massage Therapy

Your Name: _____

Have you ever had a professional massage? ____ Yes ___ No

Primary reason for a massage: __ Stress Reduction ___ Muscular Tension ___ Relaxation Other:_____

Rate your normal stress level: 1 (low) to 10 (high) _____

List your primary areas of discomfort or tension: _____

Do your exercise or regularly participate in sports? ___ Yes ___ No
If yes, describe the activities and frequency:_____

Do you eat a balanced diet? ___ Yes ___ No

Rate your general consumption of the following:

	Heavy	Moderate	Light	None
Alcohol	□	□	□	□
Caffeine	□	□	□	□
Tobacco	□	□	□	□
Sugar	□	□	□	□

Have you been hospitalized in the last year? ___ Yes ___No *If Yes, describe:* _____

Please check any chronic symptoms you have:

□ Abdominal Pain	□ Chest Pain	□ Constipation
□ Digestive Problems	□ Dizziness	□ Depression
□ Fatigue	□ Insomnia	□ Migraine Headaches
□ Sinusitis	□ Other: _____	

Please list any other conditions or health concerns that the massage therapist should be aware of.

_____

_____

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I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulation. It has been made very clear that massage therapy is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Please sign: _____ Date: _____