healing hands
massage • spa • boutique • salon

Our services are done by licensed professionals. This time is for you. Please communicate any concerns or discomforts during your session. ENJOY your treatment!

PERSONAL INFORMATION • • •

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Phone #: Home (____) ____ - _____ Mobile (____) ____ - _____

Email (*for appointment reminders + specials*): _____

Occupation: _____ How did you hear about us? _____

Hobbies/Exercise: _____

MEDICAL HISTORY • • •

1. All Recent/Past Injuries & Surgeries: _____

2. Currently Under Doctor's Care? YES NO Conditions: _____

3. Medications: _____

4. **Conditions - WE MUST KNOW FOR YOUR SAFETY! (circle all that apply):**

Allergies (accutane - shellfish - cosmetics - coconut/nut) List Other Allergies: _____

Asthma	Headaches/Chronic	Metal bone pins or plates
Back/Shoulder Conditions	Head or Neck Injuries	Pacemaker
Broken Bones	Hepatitis	Psychological
Cancer (current or remission)	Herpes	Sinus Problems
Cardiac Problems	High Blood Pressure	Skin Diseases
Diabetes	Hypertension	Surgeries
Eczema	Hysterectomy	Urinary or Kidney Problems
Epilepsy	Immune Disorders	Varicose Veins
Fever Blisters	Lupus	

MASSAGE • • •

1. Have you received a professional massage before? YES NO

2. Are you pregnant or planning? YES NO 3. Are you wearing contacts? YES NO

4. What do you need out of your massage? _____

5. Questions/Concerns? _____

6. Stress level? HIGH - MEDIUM - LOW

SIGNATURE: _____ DATE: _____

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SPA TREATMENT • • •

1. Is this your first treatment? YES NO
2. Are you taking birth control? YES NO
3. Do you wear contact lenses? YES NO
4. Do you smoke? YES NO
5. Are you using or have you ever used Accutane? YES NO
6. What other body treatments have you had? _____

   If yes, was it a good experience? _____
7. What is your stress level? (circle best answer) HIGH MEDIUM LOW
8. Do you have any allergies to cosemetics, foods, seaweed, shellfish, or drugs? YES NO

   If yes, please list _____
9. What products do you use presently? _____

FACIAL OR WAXING • • •

1. Allergies List _____
2. Are you currently being treated with chemotherapy? YES NO
3. Have you used any Glycolic or Alpha Hydroxy Acid products in the last 48 hours? YES NO
4. Are you currently using Retain A products? YES NO
5. Have you recently received a chemical peel? YES NO
6. Have you used Acutane in the past 6 months? YES NO
7. Have you used Renova recently? YES NO
8. Are you exposed to sun on a daily basis? YES NO
9. Do you regularly use a tanning bed? YES NO
10. Are you taking any medications, being treated by a Dermatologist or Plastic Surgeon for any conditions or surgery? If so, please explain: _____

This is to acknowledge that I have been informed of all aspects of my waxing service and that I understand that I may experience possible redness and or skin irritation's. It is with this understanding that I agree to have these services and I accept all responsibility for such thereby releasing the Spa and the service provider from liability. I am over/under twenty one years of age.

SIGNATURE: _____ DATE: _____