Client Information

SKIN CARE FORM

Name_______________________________ Date of Birth _____________E-mail _______________________

Cell Phone (____) ________________________ Home Phone (____) ________________________________

Address ______________________________City _____________________State ______ Zip _____________

Referred by: ____Phone (_____) ______________________

In case of emergency: ___________________________________Phone (_____) ______________________

Occupation ____ ☐Male ☐Female

Health Insurance Carrier ____

What concerns you most about your skin? (Check all that apply)

- ☐ Fine lines/wrinkles
- ☐ Blemishes/acne
- ☐ Body cellulite/stretch marks
- ☐ Dry, dull or sagging skin
- ☐ Post-acne marks
- ☐ Rough skin/ingrown hairs
- ☐ Age spots, sun spots, or freckles
- ☐ Redness/sensitivity
- ☐ Preventing fine lines or wrinkles

- Are you Claustrophobic? ☐Yes ☐No
- Have you ever experienced a professional skin treatment session? ☐Yes ☐ No
- If yes, how recently? ____
- What are your skin care goals? ____

Health History

☐ Heart Condition ☐ Lymph Edema ☐ Herpes/Shingles ☐High Blood Pressure ☐ Low Blood Pressure
☐ Numbness/Tingling ☐ Sinus Problems ☐ Allergies ☐ Cancer ☐ Rashes ☐ Jaw Pain/TMJ
☐Diabetes ☐ Headaches ☐ Arthritis ☐Pregnancy (__ weeks) ☐ Other _______________________

Skin Care

1. Are you under the care of a dermatologist? ☐Yes ☐No
2. Do you use: ☐Accutane ☐Retin A ☐Renova ☐Adapalene ☐Other prescription skin products
3. Have you ever had a ☐Chemical Peel ☐Microdermabrasion ☐Botox ☐Other resurfacing treatments
4. Are you currently using products that contain: ☐Glycolic Acid ☐Lactic Acid ☐Hydroxy acid ☐Vitamin A
5. Do you have any skin sensitivities or irritants? ___________________________ **OVER →**

Skin Maintenance

1. Products you use: ☐Soap ☐ Cleanser ☐Toner ☐Moisturizer ☐Exfoliator ☐Masque
2. Skin Type:☐ Oily/Congested ☐Dry/Dehydrated ☐Sensitive/Redness ☐Acne ☐ Sunburned ☐Eczema ☐ Psoriasis
3. Have you tanned in the last 24 hours? ☐Yes ☐No ____________________________________
4. Are you allergic to any of the following? ☐Cosmetics ☐Medicine ☐Food ☐Animals ☐Sunscreens ☐Iodine ☐Pollen ☐Ahas ☐Fragrance ☐Shellfish ☐Latex ☐Other ___________

General Health

1. Rate your level of stress (5 = highest 1 = lowest) _______________________________________
2. List your stress or other stress reduction activities: ____________________________________
3. Do you wear contact lenses? ____
4. Do you smoke? ☐Yes ☐No How many cigarettes per day? ____________________________
5. Do you have any metal implants, a pacemaker or body piercings? _________________________
6. List the medications you are currently taking: ____
   ____

It is my choice to receive spa therapies. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update Ultimate Massage Spa of any changes in my health status. I understand that Estheticians, Massage Therapists and all other service providers do not diagnose illness, disease or physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals or perform a primary health care provider for that service. If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case, I will call ASAP. Excessive missed appointments will result in a pre-payment scheduling basis. I understand that any illicit or sexual suggestive behavior, remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled services.

Client Signature ____ Date: ____________________

Consent to Treatment of Minor: By my signature below, I hereby authorize all Ultimate Massage Spa therapists to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian ____________________________ Date _______________________