Day Spa Client Intake Form

Date: ____________________

Name: ____ Date of Birth: _________________________________

Address: ____ City: _________________________ST:_______ Zip:_______

Email: ____ Phone: ___________________________________

Occupation ___________________________________

How did you hear about Skin Renew Day Spa? ____

What are your main concerns? ____

How long have you been experiencing your current condition? ____

Have you had any injuries or surgeries that may affect today's treatment? ____

What service(s) are you interested in? Please check all that apply.

Waxing	Age/Sun Spots	Chemical Peels	Facials	Rosacea
HydraFacial	Acne Scarring	Microdermabrasion	Microneedling	Stretch Marks
Therapeutic Message	Lash Lift/Tint	Tattoo Removal	Skin Tightening	Other: ___________

Please check the products that you currently use and list the brand names:

Cleanser _____________________	Exfoliant __________________	Sunscreen __________________
Sunscreen ____________________	Vitamin A _________________	Eye Cream ___________________
Vitamin C ____________________	Moisturizer __________________	Other ________________________

What is your skin type?

Dry Combination Oily Normal

Are you using any topical creams or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? If so, please list them. ____

Medical History

This information is necessary for your procedure. Please answer the following questions:

Are you using any prescribed medications?	No	Yes _____________________
Are you using any light-sensitive medications?	No	Yes _____________________
Do you have ALLERGIES including allergies to any cosmetic ingredients, medications or foods?	No	Yes _____________________
Are you pregnant or trying to become pregnant?	No	Yes (If yes, # weeks _______)
Are you breastfeeding currently?	No	Yes
Do you use tanning beds?	No	Yes
Do you wear contacts?	No	Yes
Do you have any autoimmune disorders?	No	Yes _____________________

Do you currently or have you had skin cancer?	No	Yes (If yes, when? ____________________)
Have any injuries or broken bones in the past 2 years?	No	Yes (If yes, explain? ____________________)
Bruise easily or have sensitivity to touch or pressure?	No	Yes (If yes, explain? ____________________)
Have high blood pressure and/or take medication to manage blood pressure?	No	Yes (If yes, please list____________________)
Have a contagious illnesses or diseases?	No	Yes (If yes, please list____________________)

Have you ever undergone any of the following treatments?

Cosmetic Surgery (including eye surgery)
If so, when? ____________ What area? ____________ By whom? ____________

Filler or Facial implants
If so, when? ____________ What area? ____________ By whom? ____________

Botox
If so, when? ____________ What area? ____________ By whom? ____________

Do you have any of the following medical conditions (check all that apply)?

Psoriasis	Dermatitis	Eczema	Vitiligo	Swelling
Melasma	Herpes Simplex/Blisters	Keloid Scarring	Fever Blisters	Arthritis
Cystic Acne	Cold Sores	Eye Disease	Watery Eyes	Osteoporosis
Bell's Palsy	Eye Infections	Hayfever	Varicose Veins	Headaches

Other: ______________________

In addition to the above, please tell us which conditions concern you have (check all that apply):

Acne	Scarring	Sun Damage	Unwanted Hair	Brown Spots
Pimples	Sun Spots	Clogged Pores	Uneven Skin Tone	White Spots
Wrinkles	Dry patches	Enlarged Pores	Excessive Oiliness	Blood Vessels
Blackheads	Bumps Under Skin	Upper Lip Lines	Whiteheads	Other: _______

Please check any service below that you have had done in the last YEAR:

Eyelash or Eyebrow Tint	Microblading	Eyelash Extensions	Eyelash Lift or Perm
Semi-Permanent Mascara	Microshading		

Did you have any reactions to the services above? If yes, please explain:

____

In addition to the above, please check yes to all that apply to you:

Any areas to avoid during massage? ____

What are your goals for today's treatment or areas to focus on for massage? ______________________________

What kind of pressure do you prefer for massage? ____ LIGHT ____ MEDIUM ____DEEP

I understand that the massage/bodywork/spa treatment I receive is provided for the sole purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the massage therapist so that the treatment, pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose or prescribe or treat any physical or mental illness. I affair that I have stated all my known medical conditions and answered questions honestly. I agree to keep the massage therapist updated to any changes in my medical profile and understand there should be no liability on Skin Renew Day Spa if I fail to do so. I also understand that any illicit or sexual or suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for full payment of the scheduled appointment.

Client Name ______________________________ Client Signature ______________________________ Date ________

Skin Renew Day Spa Staff ____ Date ____________________