

Spa Therapy Wellness Center Health Information Form

PLEASE COMPLETE ALL FIELDS AND BOXES THAT APPLY BEFORE YOU PRINT FORM. THANK YOU.

Date: _____ Name: _____ DOB: _____ Email: _____
Address: _____ City: _____ Zip: _____ Referred by: _____
Home Phone: _____ Cell: _____ Occupation: _____

Mark all that apply:

Vascular Disease	Joint Pain	Redness,Swelling,Heat,Pain	Spine Pain	Cancer
Heart Problems	Take Fiber	Skin infection or Ulcerations	Overweight	Thyroid
Hypertension	Menopause	Migraines / Headaches	Take Multi-Vitamin	Low Energy
Hemorrhage	Restricted Diet	Menstrual Cramps (PMS)	Snack Between Meals	Smoke
Epilepsy	Improper Diet	Hormone Imbalance	Crave Sweets	Sinusitis
Kidney Problems	Indigestion	Muscle Problems	Health Club Member	Diabetes
Implants	Pacemaker	Appetite Suppressant Meds	Infectious Bone or Joint	

Allergies, explain:

Please Answer the Questions Below:

Have you been under a Physician's care within the last year? Excluding routine physicals. **YES** **NO**

If yes, what was the treatment for?

Have you had any Surgeries? **YES / NO** if yes, please list all Surgeries.

Are you taking any Medications? **YES / NO** if yes, please list all Medications you are taking

Are you taking any Vitamins? **YES / NO** if yes, please list vitamins.

1) How much water do you consume daily?

1-2 3-5 6 or more

2) How many alcoholic beverages do you consume weekly?

None 1-2 3-5 6 or more

3) Do you drink caffeinated beverages? **YES** **NO**

4) Do you take laxatives or diuretics? **YES** **NO**

5) Do you take stimulants or diet tablets? **YES** **NO**

6) Type of massage pressure do you prefer? **Light** **Firm**

Weight: _____ Daily Meals: **B** **L** **D**

What is your goal for today's treatment?

Do you have any work-related injuries? if yes, please explain.

Skin Care

Do you experience any skin irritation? **YES** **NO**
 Do you experience ingrown hair? **YES** **NO**
 Do you experience skin breakouts? **YES** **NO**

Mark all that apply:

Do you experience any of these conditions?

Flakiness Tightness Dryness
 Rosacea Oiliness Hyperpigmentation
 Acne Other:

What type of skin care products do you currently use?

Cleanser Moisturizer Sunscreen

Exfoliation Mask

Other:

Check the box(es) below that apply:

- I am interested in Mineral Make-Up
- I am interested in skin care recommendations
- I am using prescription skin care products
- I wear sunscreen all year round

CONSENT FOR TREATMENT

I affirm that I have stated all my medical conditions and medications. I have answered all the questions honestly. I agree to indemnify, and hold harmless Spa Therapy Wellness Center and Therapist(s) from and against any and all claims, demands, loss or liability of every nature, for injuries to person and/or property, occurring in or about or in any way connected with Spa Therapy Wellness Center. I agree to keep Spa Therapy updated in the event that my medical condition changes. You will be requested to update your health information record every two (2) years. I consent to care by Spa Therapy professional staff and have read and understand consents that apply to my service.

If I fail to keep an appointment by neglecting to cancel my appointment within 24 hours, I will pay Spa Therapy 50% of the fee for the missed appointment. I acknowledge that I am ultimately responsible for payment in full for all services, whether billing is performed or not. I am of lawful age and have read and fully understand the contents of this document and the complete terms and conditions herein. This agreement contains the complete agreement between parties and no other guarantees or refunds will be given on products or services.

Name:

Date:

Please sign form after printing. Arrive 5-10 minutes before your first appt. for spa tour.

GREEN OPTION 'SAVE & SEND' TO US!

<http://sodapdf.com/gettrial.aspx>

click on this link and run sample program on your computer to save the changes in this form and email to us without printing! Thank you.