Essentials Day Spa of Palm Harbor — Client Intake Form

Name:	Occupation:
Address:	Date of Birth:
City: State: Zip:	How did you hear about us?
Email:	Cell Phone:
Emergency Contact Name/Number:	

General Health

Circle your level of stress (1 = lowest, 5 = highest) : 1 2 3 4 5

What helps reduce your stress?

Do you smoke? ▢ Yes ▢ No How many cigarettes per day? _____

Do you wear any of the following? Contact lenses: ▢ Y ▢ N Dentures: ▢ Y ▢ N Hearing Aid: ▢ Y ▢ N Other:

Do you have any metal implants, body piercings (including ears), or a pacemaker? ▢ Yes ▢ No

List any accidents or surgeries within the last 9 months: _____

List all medications your are currently taking, including supplements: _____

Health History (please check all that apply)

▢ Heart Condition	▢ Lymphedema	▢ Herpes/Shingles	▢ High / Low Blood Pressure
▢ Numbness / Tingling	▢ Sinus Problems	▢ Varicose Veins	▢ Rash
▢ Jaw Pain / TMJ	▢ Blood Clots	▢ Sprains / Strains	▢ Diabetes
▢ Gas / Bloating	▢ Headaches	▢ Arthritis	▢ Spasms / Cramps
▢ Broken / Fractured Bones	▢ Fatigue / Sleep Disorder	▢ Depression / Anxiety	▢ Cancer

Other (please explain) _____

Are you pregnant? ▢ Yes ▢ No (If Yes, how many weeks) _____

Do you have chronic pain? ▢ Yes ▢ No (if Yes, where and for how long) _____

For Massage Only

Have you ever had a professional massage? ▢ Y ▢ N When: _____

Is there any area you want to ***focus on***? _____

Are there any areas to ***avoid***? _____

Are you looking for: ▢ Relaxation ▢ Pain Relief ▢ Stress reduction

Type of Massage: ▢ Relaxation ▢ Therapeutic ▢ Deep Tissue

Your Preferred Pressure:
- ▢ Light
- ▢ Moderate
- ▢ Firm
- ▢ Deep

For Skin Care Only

Are you under the care of a dermatologist? ▢ Yes ▢ No

Do you use: ▢ Accutane ▢ Retin A ▢ Renova ▢ Adapalene ▢ Other prescription skin projects

Have you ever had a: ▢ Chemical Peel ▢ Microdermabrasion ▢ Botox ▢ Other resurfacing treatments

Are you currently using any product that contains: ▢ Glycolic Acid ▢ Lactic Acid ▢ Hydroxy Acid ▢ Vitamin A

Do you have any skin sensitivities, allergies or irritants? _____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it superseded any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation from treatments received. The treatments I receive here are voluntary and I release this institution and individual therapist from any and all liability and assume full responsibility thereof. For minors under the age of 18, a parent or guardian signature constitutes consent.

Client or Parent Signed: _____ **Today's Date:** _____

Privacy notice: No information about any client will be discussed or shared with any third party without express written consent of the client or parent / guardian if the client is under 18.