CLIENT INFORMATION AND RELEASE FORM

Required Insurance Treatment Consent and Release Form:

I acknowledge that the practice of massage, nail and skin care treatments including microdermabrasion, microablation, electrolysis, facials, body treatments, facial toning, TPR treatments, laser treatments, waxing and various other beauty treatments are not an exact science and no specific guaranties can or have been made concerning the expected result. I understand some clients experience more change or improvements than others. In virtually all cases, for improvements to become apparent, multiple treatments are required. I also realize that the following risks and hazards may occur in connection with any particular treatment including but not limited to; unsatisfactory results, poor healing, discomfort, redness, blistering, nerve damage, scarring, change in skin pigmentation, any increased hair growth. I understand though every precaution will be taken, not all risks can be known in advance. I understand that response to treatment varies on an individual basis and specific results are not guaranteed. I also agree to hold harmless and release from any liability THE DAY SPA AT SALON ELIZABETH, INC. as well as any officers, directors or employees of THE DAY SPA AT SALON ELIZABETH, INC. For any conditions or results, known or unknown that may arise as a result of any treatment that I have received.

I understand that some medical conditions may be worsened by massage therapy, and for this reason a referral from my primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage/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 aliment that I am aware of. I understand that massage therapists/body workers are not qualified to perform any spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session's) given should be construed as such.

Because massage/bodywork is contraindicated (should not be done) under certain conditions, I affirm that I have stated all known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Print Name:_____

Signature:_____ Date:_____

REMARKS

_____

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THE DAY SPA AT SALON ELIZABETH INC. CONFIDENTIAL CLIENT ANALYSIS RECORD

Print Name:_____ Date of Birth:___/___/___Date 1st Visit:__/__/__
Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Recommended By:_____
Office Phone:_____ Occupation:_____
Cell Phone:_____ Physician:_____Phone:_____
E-MAIL:_____

EMERGENCY CONTACT_____**PHONE**_____

Previous Hair Removal Treatment: Electrolysis ___ Laser ___

Used Previously: Bleaches__ Scissors__ Depilatories__ Tweezers__ Wax__ Razors__ Other__

GENERAL HEALTH RECORD	**YES**	**NO**	
Any Cancer Including Skin	_____	_____	Explain: _____
Burning, Itching Skin Condition	_____	_____	Explain: _____
Warts	_____	_____	Explain: _____
Menopause/Hormone Problems	_____	_____	Explain: _____
Heart Problems/Pacemaker	_____	_____	Explain: _____
Medications You Take	_____	_____	Explain: _____
Plastic or Laser Surgery	_____	_____	Explain: _____
Any Other Recent Surgery	_____	_____	Explain: _____
Cosmetic Implants, Pins	_____	_____	Explain: _____
Do you use Retina A/Accutane	_____	_____	Explain: _____
Allegeries	_____	_____	Explain: _____
Claustrophobic	_____	_____	Explain: _____
Asthmatic	_____	_____	
Nervous Tension	_____	_____	
Sinus Headaches	_____	_____	
Wear Contact Lenses	_____	_____	
Smoke	_____	_____	
Trouble Sleeping	_____	_____	
Exposed to Sun or Sun Beds	_____	_____	
Use Glycolic Acid	_____	_____	
Have you had an Acid Peel	_____	_____	

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

Arthritic:_____ Hodgkins:_____ Pregnant:_____
Diabetic:_____ Rheumatic Fever:____
Epileptic:_____ Hemophiliac:_____
Hepatitis:_____ HIV or AIDS:_____
Products you use to cleanse face_____
When was your last Facial:_____

	YES	**NO**		**YES**	**NO**
Had a Professional Massage	_____	_____	Have you had a Fall/Accident	_____	_____
Had any Broken Bones in 2 Year	_____	_____	Sensitive to Touch Anywhere	_____	_____
Low Back Pain	_____	_____	Pain down Arms or Legs	_____	_____
Any Spinal Problems	_____	_____	Blood Clots	_____	_____
Chronic Bowel Problems	_____	_____		_____	_____

Explain:_____
Explain:_____
Explain:_____
Explain:_____

Professional Skin Analys : Below to be FILLED OUT by Technician

Notes:_____
_____

Dry:_____ Rosacea:_____ Enlarged Pores:_ Psoriasis:_____ Pits:_____
Mature Dry:_____ Acne:_____ Eczema:_____ Capillaries:____ Scars:_____
Oily:_____ Sensitive:_____ Moles:_____ Lines:_____ Freckling:_____

Normal:_____ Blemished:_____ Pigmentation:___ Wrinkles:_____ Chloasma:_____
Combination:_____ Crepe Neck:_____ Skin Tags:_____ White/Black Head: Hirsutism:_____