Client Survey

*Please PRINT legibly.

Last Name: _____ First Name: _____ Middle Int.:_____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: (____) ____-_____ Work Phone: (____) ____-_____

Cell Phone: (____) ____-_____ Date of Birth: ___/___/_____

E-mail: _____@_____.com

Emergency Contact: _____ Relation: _____Phone# :(____) ____-_____

How did you hear about us? _____ Your Profession: _____

Preferred Method of contact for appointment confirmations: _____

Please check all that apply and explain on lines listed below:

☐ Allergies	☐ Back/Hip Pain	☐ Osteoporosis	☐ Fibromyalgia
☐ AIDS/HIV+	☐ Asthma	☐ Rheumatoid Arthritis	☐ Broken/Fractured bone
☐ Cancer	☐ Dizziness	☐ Herpes/Shingles	☐ Carpal Tunnel
☐ Fainting	☐ Muscular Dystrophy	☐ Depression	☐ Spasms/Cramps
☐ Headaches	☐ Disc Problems	☐ Spinal Problems	☐ Numbness/Tingling
☐ Paralysis	☐ Pregnant	☐ Heart Condition	☐ Sprains/Strains
☐ Diabetes	☐ Neck Problems	☐ Tendonitis	☐ Parkinson's disease
☐ Stroke	☐ TMJ, Jaw pain	☐ Sleep Disorders	☐ Recent Surgeries
☐ Eczema	☐ Psoriasis	☐ Osteoarthritis	☐ Varicose Veins
☐ Latex Sensitivity		☐ High/Low Blood Pressure	
☐ Hyper/Hypothyroid	☐Rosacea	☐ Lymphedema	☐ Fever Blisters/Cold Sores
☐Warts (Hands &/or Feet)			

Explanation(s):_____
_____
_____
_____
_____
_____

Please List All Allergies (Food, Products, etc.)
_____

Are you currently pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

List current medications: _____
_____
_____

Are you currently using Accutane or Retin-A? ☐ Yes ☐ No

Are you currently seeing a chiropractor, physical therapist, or physician for an ongoing issue?☐ Yes ☐ No
Have you received massage therapy before? ☐ Yes ☐ No If yes, when was your last session? _____
Desired pressure: ☐ Light ☐ Firm ☐ Deep

Have you received a facial before? ☐ Yes ☐ No If yes, when was your last session? _____

Are you currently seeing a dermatologist? ☐ Yes ☐ No If yes, when was your last session? _____

Have you received a wax service before? ☐ Yes ☐ No

If yes, did you experience any unusual reaction from waxing? ☐ Yes ☐ No

Are you sensitive to makeup? ☐ Yes ☐ No

If so, what brands? _____

How often do you wear make up? ☐ Everyday ☐ 4-6 times/week ☐ 2-3 times/week ☐ 1/week ☐ none

On the average day, what kind of make up do you wear? ☐ foundation ☐ powder ☐ eye shadow ☐ eye liner ☐ mascara ☐ supplemental lashes ☐ blush ☐ lip liner ☐ lipstick/gloss
☐others:_____

What facial cleansing and moisturizing products and makeup do you currently use (brand and name)?
_____

_____

_____

Service Agreement and Liability Release Waiver

***Please initial next to each statement. Then, sign and date the form.**

☐ You understand that the services you receive from Beauty by Bowers Day Spa are provided for the basic purposes of beauty, skin care education, relaxation, and relief of muscular tension.

☐ Modesty draping will be utilized. Body parts addressed will be only those that directly pertain to the service.

☐ You understand that Beauty by Bowers utilizes various temperatures and mediums, including but not limited to: steam, wax, heat, cold, etc. It is your responsibility to ensure that your esthetician/therapist has been made aware and issues with temperature or mediums.

☐ You understand that it is your responsibility to inform Beauty by Bowers and your esthetician/therapist of any pre-existing conditions, limitations, or specific sensitivities and to inform your esthetician/therapist immediately if you feel any discomfort during your spa services.

☐ You understand that because spa services should not be performed under certain medical conditions, you affirm that you have stated all of your known medical conditions and answered all questions honestly. You agree to keep the esthetician/therapist updated as to any changes in your medical profile and understand that there shall be no liability on the esthetician's/therapist's part or Beauty by Bowers Day Spa should you fail to do so.

☐ You understand that should you have a medical condition; you affirm that you have been cleared by your doctor/presiding medical care giver to receive spa related services; also, that any spa service that you request is cleared by your doctor/presiding medical care giver.

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

☐ **You understand that cancelled appointments without a 12 hour notice or missed appointments will be charged at 50% of the scheduled session cost.**

☐ **You understand that we will not service any person under the age of 18 without a liability release waiver signed on their behalf by their legal parent, legal guardian, or legal custodian.**

☐ Beauty by Bowers is committed to providing the utmost professional service; if you are dissatisfied at any time, promptly notify a member of the Beauty by Bowers management team. Complaints not received within 48 hours after the initial rendering of services may not be honored.

All information is confidential. It is the policy Beauty by Bowers Day Spa, LLC to shun practices of selling personal information. Additionally, We adhere to the governing Federal guidelines of HIPAA. For more information, please visit www.hipaa.org.

☐ YOU UNDERSTAND AND VOLUNTARILY ACCEPT ANY RISKS ASSOCIATED WITH YOUR SPA SERVICES AND UNDERSTAND, BEAUTY BY BOWERS DAY SPA, LLC., ITS EMPLOYEES, OR AFFILIATES WILL NOT BE HELD LIABLE FOR ANY INJURY OR DAMAGE, INCLUDING, WITHOUT LIMITATION TO: PERSONAL, BODILY, OR MENTAL INJURY, ECONOMIC LOSS, OR ANY OTHER DAMAGE TO YOU, YOUR SPOUSE, GUEST, UNBORN CHILD, OR OTHERS RESULTING FROM BEAUTY BY BOWERS OR ANYONE ACTING ON BEHALF OF BEAUTY BY BOWERS.

☐ **You have read and understand the Beauty by Bowers payment policies.**

☐ Beauty by Bowers Day Spa reserves the right to refuse services at any time, for any reason.

By signing and dating below, you acknowledge that you have read, understand, and agree to the entirety of this Liability Release Waiver.

Client's Printed Name: _____

Client's Signature: _____
Date: ____/____/_____

Print name of minor (under the age of 18): _____

Print name of Legal Parent/Guardian/Custodian: _____

Legal Parent/Guardian/Custodian Signature_____
Date: ____/____/_____

Witness: _____ Date: ____/____/_____