Client Intake Form

Name: _____ Date: _____
Last First

Address: _____ City: _____ ST: _____ Zip: _____

Email: _____ Phone: _____

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? _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? ☐ Yes ☐ No
   If yes, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? ☐ Yes ☐ No
   If yes, please explain _____
3. Do you have any allergies to oils, lotions, or ointments? ☐ Yes ☐ No
   If yes, please explain _____
4. Do you have sensitive skin? ☐ Yes ☐ No
5. Are you wearing contact lenses ☐ dentures ☐ a hearing aid ☐?
6. Do you sit for long hours at a workstation, computer, or driving? ☐ Yes ☐ No
   If yes, please describe _____
7. Do you perform any repetitive movements in your work, sports, or hobby? ☐ Yes ☐ No
   If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? ☐Yes ☐No

   If yes, how do you think it has affected your health?

   Muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other _____

9. Is there a particular area of the body where you are expecting tension, stiffness, pain, or other discomfort?

   ☐Yes ☐No

   If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? ☐Yes ☐No

    If yes, please explain _____

11. Are you currently under medical supervision? ☐Yes ☐No

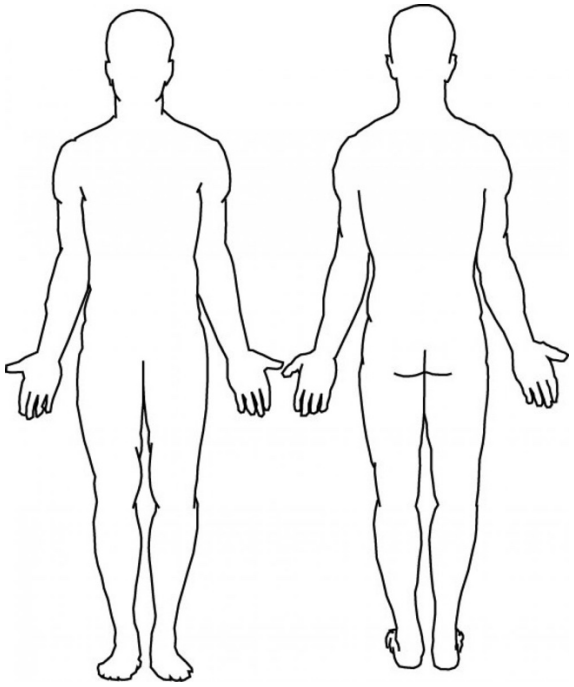
    If yes, please explain _____

12. Do you see a chiropractor? ☐Yes ☐No If yes, how often? _____

13. Are you taking any medications? ☐Yes ☐No

    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on:



14. Please check any condition listed below that applies to you:

- ☐ contagious skin condition
- ☐ open sores or wounds
- ☐ easy bruising
- ☐ recent accident or injury
- ☐ recent fracture
- ☐ recent surgery
- ☐ artificial joints
- ☐ sprains/strains
- ☐ current fever
- ☐ swollen glands
- ☐ allergies/sensitivity
- ☐ heart condition
- ☐ high or low blood pressure
- ☐ circulatory disorder
- ☐ varicose veins
- ☐ atherosclerosis
- ☐ phlebitis
- ☐ deep vein thrombosis/blood clots
- ☐ joint disorder/rheumatoid arthritis
- ☐ osteoporosis
- ☐ epilepsy
- ☐ headaches/migraines
- ☐ cancer
- ☐ diabetes
- ☐ decreased sensation
- ☐ back/neck problems
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ carpal tunnel syndrome
- ☐ tennis elbow
- ☐ pregnancy If yes, how many months? __

Draping will be used during the session – only areas being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of the muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Name _____

Client Signature _____ Date _____

Skin Renew Day Spa Staff: _____ Date _____

Massage Client Consent Form

I hereby consent to and authorize Skin Renew Day Spa & Laser Center to perform the following procedure(s):

☐ Massage ☐ Other: _____

I agree and confirm I have not started any new medications, or have not had any change in my medical or health condition since my last treatment. I understand that not disclosing the above information may cause complications with my treatments. I understand my practitioner has the right to refuse any service to me for any of the above reasons.

I have read and understand all the information presented to me before signing this consent. I release Skin Renew Day Spa and its practitioners from liability associated with the treatments I am requesting them to perform.

Client Name _____

Client Signature _____ Date _____

Skin Renew Day Spa Staff _____ Date _____

Use/Disclosure of Health Information

I authorize Skin Renew Day Spa to communicate with me via email, text or phone reminders prior to my appointments at Skin Renew Day Spa at the contact information provided to Skin Renew Day Spa. This form requests you to advise: (A) *to whom we may disclose information* (B) *the reason for disclosure*, and (C) *the information to be disclosed.* However, to further protect your right to privacy, Skin Renew Day Spa *will not use or disclose* health information to family members, doctors, insurance companies, health insurance companies or to any other entities *without a current written authorization at the time the information is to be released.* Skin Renew Day Spa may discuss your health and/or treatment with/will provide your information to:

I, _____, hereby authorize the disclosure of my health and/or treatment information from my records to:

Name: _____
Address: _____
City/State/Zip: _____

The information I authorize to be disclosed from my health/treatment record: (initial appropriate boxes)

____ Entire Record ____ Visit Notes ____ Health & Physical ____ Medication or Problem List ____ Billing

Only information related to: _____

Please sign below to acknowledge you have read and agree with this policy.

_____
Client Signature

_____
Date

Cancellation Policy

Our staff hours are limited and valuable.

Missed appointments, being late more than 10 minutes or failure to give a 24-hour notice of cancellation or rescheduling will result in a $25 cancellation fee. If you arrive more than 10 minutes late, we may not be able to treat you. This fee will be required to be paid before any additional treatments will be performed. We understand emergencies will happen. Therefore, a fee can be waived for an emergency and this fee can only be waived one time.

We appreciate you and your business and look forward to serving you!

Thank you,
Skin Renew Day Spa

Please sign below to acknowledge you have read and agree with this policy.

_____

Client Signature

_____

Date

PRINT FORMS