RENEWAL DAY SPA

Bringing you the satisfaction of healthy skin and body for a renewed spirit

Confidential Client Information Form

For All Services. Please Print Clearly

Please silence your cell phones, thank you.

First Name:_____ **Last Name:** _____
Street Address:_____**City/State**:_____**Zip**:_____
Date of Birth: _____/_____/_____ **Email** (for promotions & confirmations)**:**_____@_____
Home Phone:_____ **Cell Phone:**_____ **Shoe Size** (for spa slippers)**:**____

How were you referred? (*ex: magazine, radio, friend, internet, other*)_____
If someone referred you, please tell us who:_____

Occupation: _____ General health condition: _____
Are you currently under a health provider's care? (*Dermatologist, Chiropractor, OB, etc*) **Yes** **No**
If yes, please specify:_____

Please mark an "X" for all current conditions below. Please mark a "P" for all past conditions. If you mark any conditions with an (*), please see the corresponding section on the back of this form.

__Skin Rashes/Disorders
__Acne
__Bruises/Cuts
__Heart/Blood Conditions
__High/Low Blood Pressure
__Varicose Veins
__Clotting disorders/Blood clots
__Circulatory Disorders
__Kidney Disorders
__Sleeplessness
__Allergies
__Inflammation
__Diabetes/Hypoglycemia
__Digestive Problems
__Crohn's/Colitis/IBS
__Asthma/Lung Conditions
__Flu/Cold/Any Infections
__Herpes I / II / Cold Sores
__Athletes Foot
__Arthritis/Gout
__Parkinson's
__Osteoporosis
__Neck/Spine Disorders
__Swelling/Lymphedema
__Numbness/Tingling/Neuropathy
__Carpal Tunnel
__Acute Pain/Chronic Pain
__Fever
__Fibromyalgia
__Headaches/Migraine
__Joint/Muscle Pain
__Joint Replacement/Other Implants
__T.M.J Syndrome
__***Cancer/Tumors****
__***Lymph Node Removal****
__***Chemotherapy/Radiation****

Other medical conditions not listed: _____

Are you taking any medications (include **antibiotics*, steroids***, **blood thinners*,** herbs or vitamins) for any health problems, conditions, or disorders? If yes, please list and explain:_____
_____
_____

Please list any surgeries, accidents, or injuries & when: _____
_____
_____

Do you have any difficulty lying on your front __, back __, or side __ ? (check all that apply)

Do you smoke? **Yes** **No** Do you use skin peeling agents /exfoliants? **Yes** **No**
Have you ever used Accutane? **Yes** **No** Do you burn easily in the sun? **Yes** **No**

Have you ever had a reaction to any of the following?
__Cosmetics
__Fragrances
__AHA's (Glycolic/Lactic Acid)
__Sunscreens
__Nuts
__Aspirin
__Blood Thinners
__Benzoyl Peroxide
__Other:_____

Female clients:
Are you **pregnant or trying to become pregnant?*** **Yes** **No**
Are you currently experiencing symptoms of pre-menopause or menopause? **Yes** **No**

***A client undergoing *chemotherapy or radiation* is not a candidate for any spa services.**

***A client taking *steroids or antibiotics* is not a candidate for massage or skincare services.**

Cancer/Tumors/Lymph Node Removal/Chemotherapy/Radiation:
Date of last treatment _____

If you are *pregnant* (or may be pregnant):

Please note that massage should not be received in the first 12 weeks of pregnancy.
How many weeks? _____ Expected due date: _____
# of previous pregnancies_____ # of previous deliveries_____

Do you have a history of (please check all that apply):

__High blood pressure	__Low blood pressure	__Pre-term labor
__Edema/Swelling	__Thyroid problems	__Headaches
__Morning sickness/Nausea	__Sinus congestion	__Heartburn
__Constipation	__Diarrhea	__Hemorrhoids
__Varicose Veins	__Miscarriage	

Have you ever received a pregnancy massage before? **Yes** **No**

For All Clients

I confirm, to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. All answers above may be discussed with me during my consultation. I understand that if I experience any pain or discomfort during my treatments, I will immediately inform the therapist so that the pressure, application or service may be adjusted to my level of comfort. I understand that if I have any medical condition I should see a qualified, physician, chiropractor, or other professional healthcare specialist, and that staff may require a doctor's note at their discretion. I understand that certain medical conditions may make me ineligible to receive services. I understand only a doctor is qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of a service with any other person should be construed as such. I agree to hold Renewal Day Spa & Nails and all of its agents free from all liability if I withhold any information.
To secure an appointment, a credit card is required. I understand 24 hour notice is required for the change, cancellation, or reschedule of any appointment. Packages with 3 or more services require 48 hour notice. Failure to do so will result in a **Full Charge** of the service**.** Missing any appointment without notice will result in a charge for 100% of each service missed. I further understand that tardiness may result in my appointment being cut short, and will be charged full price. Renewal Day Spa reserves the right to ask me to leave for any inappropriate behavior or requests. In such cases, payment will be due in full. All information will be kept confidential.

Client Signature:_____**Date:**_____