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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*Independently Owned and Operated by** Click here and enter business name. | | | | | | | | | | | | | |
| **GENERAL INFORMATION** | | | | | | | | | | | | | |
| Name: | | | | | | | Today’s Date: | | | | Occupation: | | |
| Address: | | | | | City: | | | | | | | State: | Zip: |
| Phone:       Cell: | | Date of Birth (MM/DD/YY): | | | | | Email: | | | | | | |
| Emergency Contact Name:       Phone: | | | | | | | | | How did you hear about us? | | | | |
| Preferred Method of Communication: Email  Phone | | | | Name Of Person Who Referred You: | | | | | | | | | |
| **GENERAL HEALTH** | | | | | | | | | | | | | |
| 1. Rate your level of stress (1 = lowest, 5 = highest): 1  2  3  4  5 | | | | | | | | | | | | | |
| 1. What physical activities do you enjoy? | | | | | | | | | | | | | |
| 1. Do you wear contact lenses?  YES  NO | | | | | | | | | | | | | |
| 1. Allergic to Aspirin?  YES  NO or Skin Sensitivities/General Allergies?  YES  NO Please be specific: | | | | | | | | | | | | | |
| 1. Do you smoke?  YES  NO If yes, how many cigarettes per day? | | | | | | | | | | | | | |
| 1. Please list any accidents or surgeries in the last 12 months:   *(If you have had surgery within the past* ***12*** *months please complete our* ***Post Surgery Massage Consent Form****)* | | | | | | | | | | | | | |
| 1. Do you have: Metal Implants?  YES  NO A Pace Maker?  YES  NO Body Piercings?  YES  NO | | | | | | | | | | | | | |
| 1. List the Medication(s)/Supplement(s) you are currently taking: | | | | | | | | | | | | | |
| 1. Are you currently taking:  Antibiotic  Birth control  Hormone Replacement  Blood Thinners  N/A | | | | | | | | | | | | | |
| **HEALTH HISTORY – Please check here if none apply** | | | | | | | | | | | | | |
| Arthritis | Irregular digestion | | Herpes Simplex Virus | | | | MRSA | | | Allergy to Iodine or Shellfish | | | |
| Circulatory Problems | Hypertension | | Eye Infection/Disorder | | | | Chronic pain | | | Osteoporosis | | | |
| Sleep Problems | Varicose veins | | Heart Disease | | | | Epilepsy | | | Serious Sun burn or exposure | | | |
| Diabetes | Claustrophobia | | Eczema  Psoriasis | | | | Sciatica | | | Hyper/Hypo Thyroid | | | |
| Facial Warts | Headaches | | Keloid/Hypertrophic Scars | | | | Sun Allergy | | | Other: | | | |
| 1. **Have you ever been diagnosed with Cancer?**  YES  NO *(If YES, please complete our* ***Oncology Intake Form****)* | | | | | | | | | | | | | |
| 1. **Are you pregnant/nursing or trying to become pregnant?**  YES  NO If pregnant how many weeks?       *If YES, complete our* ***Prenatal Intake Form****)* | | | | | | | | | | | | | |
| 1. Any other medical condition or concerns we need to know about? | | | | | | | | | | | | | |
| **MASSAGE THERAPY** | | | | | | | | **GOAL FOR YOUR MASSAGE SESSION** | | | | | |
| 1. Have you had a professional massage before?  YES  NO   If YES, when?       How Often? | | | | | | | | Relaxation  Pain Relief  Stress Reduction  Headache  Escape  Health/Wellness  Other | | | | | |
| 1. Pressure?  Light  Medium  Firm  Not Sure | | | | | | | |
| 1. Is there any part of your body you would like to focus on today? | | | | | | | | 1. **Is there any area of your body you do not want massaged?** | | | | | |
| **SKIN CARE** | | | | | | | | | | | | | |
| 1. Are you under the care of a dermatologist?  YES  NO | | | | | | | | | | | | | |
| 1. Do you use any of the following?  Accutane  Retin A  Renova  Adapalene  Resorcinol  Scrub or Peel  N/A   Other prescription skin products, please be specific: | | | | | | | | | | | | | |
| 1. Have you had any of the following?  Chemical Peel  Microderm  Botox  Dermal Filler  Permanent Cosmetics  N/A   Other resurfacing treatments, please be specific:       Any serious side effects?  YES  NO | | | | | | | | | | | | | |
| 1. Are you currently using any products that contain the following?  Glycolic Acid  Lactic Acid  Hydroxy Acid  Vitamin A  Vitamin C  N/A | | | | | | | | | | | | | |
| **SKIN MAINTENANCE** | | | | | | **Products Used – List Brand and Frequency of Use** | | | | | | | |
| 1. Skin Type:  Oily/Congested  Dry/Dehydrated   Sensitive/Redness  Acne  Sunburned | | | | | | **Soap/Cleanser**-  **SPF**-  **Toner**-  **Exfoliator**-  **Masque**-  **Moisturizer-**  **Please turn over 🡪** | | | | | | | |
| 1. Have you been tanning in the last 24 hours?  YES  NO 2. In the last week have you had:  Waxing  Electrolysis | | | | | |
| 1. What are your skin care goals? | | | | | |

It is my choice to receive spa treatments, including massage, skin care, hair removal or microdermabrasion. Because massage/bodywork, skin care and other spa treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, or answered all questions asked of me honestly. I will update Hand and Stone of any changes to my health status. I understand that Estheticians and Massage Therapists do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal manipulations or skeletal adjustments and that nothing said in the course of the session given should be construed as such. I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and that it is recommended I see a primary health care provider for that service. If I experience any pain or discomfort during the session, I will **immediately** inform the Massage Therapist or Esthetician so that the service may be adjusted to my level of comfort or discontinued. I could experience varying degrees of redness, burning, peeling, itching, etc., especially in the initial stages of a skin care program. I further understand that I am paying for a treatment and not a result and that there will be no returns, refunds or exchanges.

If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24 hour notice, I agree to pay the missed appointment fee that applies.

I understand that any illicit or sexually suggestive behavior, remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled service. Further, I understand that HAND & STONE MASSAGE AND FACIAL SPA reserves the right to refuse to administer services at their sole discretion. I have read and fully understand this form in its entirety. I hereby release the practitioners, Hand and Stone Massage and Facial Spa and their insurers, and their respective officers, directors, stockholders, successors, employees, franchisor and agents from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving massage, skin care (facials, peels), microdermabrasion or hair removal services.

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**Client Signature** Date

The information I have provided is accurate and true.

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**Client Signature** Date

***CONSENT TO TREATMENT OF MINOR: by my signature below, I authorize HAND & STONE MASSAGE AND FACIAL SPA to administer facial/massage techniques to my minor child or dependent as they deem necessary or proper.***

***SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Intake Form – Updated 4/17/2017

MT Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LE Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hand and Stone Massage and Facial Spas are independently owned and operated franchise locations.**