

**CLIENT INFORMATION: All information will be kept confidential**

Name: \_\_\_\_\_ Email: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Emergency Contact Name: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Are you celebrating a special occasion today? \_\_\_\_\_

During the session, I prefer to  talk  enjoy the silence  a little of both (the therapist will follow your lead on this as a general rule of thumb)

Which essential oils do you prefer? Select all that apply.

- Lavender  Citrus  Peppermint  Lemongrass  Eucalyptus  None

Do you have any trouble breathing, or discomfort while lying in certain positions for extended periods of time? Yes / No \_\_\_\_\_

**Health Information**

**Are you currently pregnant?** *If yes, how many weeks?* \_\_\_\_\_

**Do you have a pacemaker, rods or screws, or any other surgically implanted devices?** Yes No \_\_\_\_\_

**Please list known allergies:** \_\_\_\_\_

*Check all that apply, provide any details in the 'other conditions' space.*

- |  |  |
|--|--|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia  |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack  |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction                                      |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots   |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Numbness  |
| <input type="checkbox"/> Asthma/Allergies        | <input type="checkbox"/> Sprains or Strains                                      |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Contagious Skin Disease (herpes, shingles, foot fungus) |

**What type of skin do you have?**  Normal  Oily  Dry  Combination

*Which of the following describe your skin concerns?*

- |  |  |
|--|--|
| <input type="checkbox"/> Breakouts/Acne        | <input type="checkbox"/> Rosacea                 |
| <input type="checkbox"/> Blackheads/Whiteheads | <input type="checkbox"/> Broken Capillaries      |
| <input type="checkbox"/> Uneven Skin Tone      | <input type="checkbox"/> Redness/Ruddiness       |
| <input type="checkbox"/> Sun Damage            | <input type="checkbox"/> Sun Damage              |
| <input type="checkbox"/> Excessive Oil/Shine   | <input type="checkbox"/> Dehydrated              |
| <input type="checkbox"/> Wrinkles/Fine Lines   | <input type="checkbox"/> Sun, Liver, Brown Spots |
| <input type="checkbox"/> Dull/Dry Skin         | <input type="checkbox"/> Other                   |

**Have you been under the care of a dermatologist or any other skin care professional within the past year?**  yes  no  
If yes, please explain \_\_\_\_\_

**Do you currently or have you used:**

- |   |  |
|---|--|
| <input type="checkbox"/> <u>in the last 3 months</u>                        | <input type="checkbox"/> <u>in the last 6 months</u> |
| <input type="checkbox"/> Retin-A  | <input type="checkbox"/> Botox                       |
| <input type="checkbox"/> AHA's or Retinol/<br>Vitamin A derivative products | <input type="checkbox"/> Restylane                   |
|   | <input type="checkbox"/> Collagen injections         |

**Other conditions, diagnosis, or information:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Massage Information**

**# of past massages** \_\_\_\_\_

**Primary reason for today's visit**

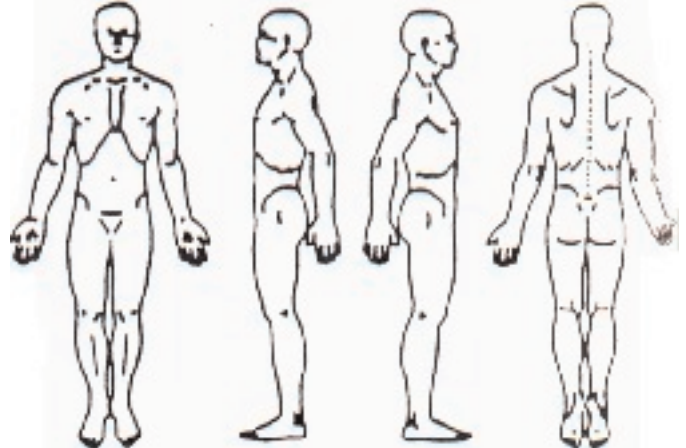
Relaxation  Pain Relief  Specific Issue \_\_\_\_\_

**Pressure Preference**  Light-Medium  Medium-Deep  Very Deep

**Are there any areas of your body you would like the therapist to focus on today?** \_\_\_\_\_

**Areas to avoid?** \_\_\_\_\_

*Please circle any areas of pain or injury*



*Your therapist wants you to have an exceptional experience. It is not rude to ask for more or less pressure or to communicate likes/dislikes. Thank you in advance for communicating your needs and allowing us to provide you with the best possible treatment plan.*

**Halotherapy Salt Session**

Please let our spa coordinator know if you need extra blankets, tissue (for those prone to sneezing) or help reclining your chair. Once the session begins, please do not open the door or leave the room with the exception of emergency. Shoe covers must be worn, no food or drink is permitted in the salt room.