Healing Elements Day Spa

2175 Continental Dr. ~ West Bend, WI 53095 ~ 262-306-6691 ~ www.HeDaySpa.com

Guest Intake Form

NAME:_____ DATE:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____
HOME Phone:_____CELLULAR:_____
WORK:_____E-MAIL:_____

WOULD YOU LIKE TO BE CONFIRMED FOR SERVICES VIA: Text Email Both
LIKE US ON FACEBOOK FOR ALL OUR CURRENT SPECIALS AND DISCOUNTS
DATE OF BIRTH:_____SEX: M F
OCCUPATION:_____
EMERGENCY CONTACT NAME & RELATIONSHIP:_____
PHONE NUMBER TO BE REACHED AT:_____
HOW WERE YOU REFERRED TO OUR DAY SPA?_____

HEALING AWAITS YOU…

HAVE YOU EVER HAD A MASSAGE? Yes_____No_____
HAVE YOU EVER HAD A FACIAL? YES_____NO_____
HAVE YOU EVER HAD A BODY TREATMENT? YES_____NO_____
ARE YOU HERE FOR HEALING OF YOUR: MIND ~ BODY ~ SPIRIT
ARE YOU CURRENTLY EXPERIENCING PAIN?_____
CURRENT MEDICATIONS (TOPICAL & INTERNAL):_____
_____
ALLERGIES OR SENSITIVIES:_____
ALLERGIC TO ANY NUTS, NUT OILS, OR LATEX?_____
SURGERIES:_____
HAVE YOU HAD CANCER_____TYPE:_____

DO YOU HAVE ANY OF THE FOLLOWING:
ARTHRITIS_____DIABETES_____HIGH/LOW BLOOD PRESSURE_____
VARICOUS VEINS_____BLEEDING DISORDER_____NAIL FUNGUS_____
DIZZINESS_____CLAUSTROPHOBIA_____HEAD INJURY_____
DO YOU HAVE A PACEMAKER? Yes_____No_____
DO YOU SMOKE? Yes_____No_____
DO YOU WEAR CONTACT LENSES? Yes_____No_____
DO YOU WEAR HEARING AIDS? Yes_____No_____
ARE YOU UNDER THE CARE OF A DERMATOLOGIST? YES_____NO_____
DERMATOLOGISTS NAME: _____
REASON FOR TREATMENT: _____
WHICH OF THE FOLLOWING DO YOU USE AND WHAT BRAND:
SOAP_____CLEANSER_____SCRUB_____
MOISTURIZER_____MASKS_____OTHER_____
HOW MUCH WATER DO YOU DRINK IN A DAY?_____CAFFEINE?_____
ALCOHOL?_____Other?_____
HOW WOULD YOU DESCRIBE YOUR DAILY LEVEL OF STRESS?_____
DO YOU EXERCISE REGULARLY? YES: _____NO:_____

OVER

FOR WOMEN:

ARE YOU PREGNANT: YES____NO____IF YES, # OF WEEKS_____

DUE DATE: _____

ARE YOU UNDER THE CARE OF A DOCTOR? YES_____NO_____

IS YOUR DOCTOR AWARE OF YOU BEING HERE? YES_____NO_____

SKIN CONDITIONS:	SUN EXPOSURE HISTORY:
PLEASE INDICATE CONCERNS: _____ACNE _____ACNE ROSACEA _____ AGING _____BACK/CHEST ACNE _____BLACKHEADS ____RAZOR BUMPS _____BURN _____CYSTIC ACNE _____DERMATITIS _____ROSACEA _____DARK UNDER-EYE CIRCLES _____DRY SKIN _____ELASTISITY LOSS _____ENLARGED PORES _____LINES/WRINKLES ____SUNBURNS _____WHITEHEADS _____OILINESS _____MOLES_____STRETCH MARKS _____PRE/POST OPERATIVE CARE _____SCARRING _____UNEVEN SKIN _____DISCOLOURATION _____BROKEN CAPPILLARIES HAVE YOU PREVIOUSLY UNDERGONE: _____MICRODERMABRASION _____PEELS, CIRCLE TYPE: LACTIC ACID GLYCOLIC ACID SALICYLIC ACID CHEMICAL	DO YOU SUNBURN/TAN EASILY? __ ALWAYS BURN, NEVER TAN __ SELDOM BURN, TAN EASILY __ NEVER BURN, TAN EASILY __ USUALLY BURN, TAN WITH DIFFICULTY APPROXIMATE SUN EXPOSURE: __ MINIMAL __ OCCASIONAL __ RECREATIONAL __ OCCUPATIONAL DO YOU USE A TANNING BED? __ YES __ NO IF YES, HOW OFTEN? _____ DO YOU USE AN SPF DAILY? __ YES __ NO IF YES _____%

WHEN WAS THE LAST TIME YOU ATE:_____

HAVE YOU RECENTLY HAD ANY SYMPTOMS OF A COLD:_____

PLEASE LIST ANY OTHER INFORMATION WE MAY NEED TO KNOW ABOUT:_____

_____

CONSENT TO TREAT:

BY SIGNING THIS CONSENT I GIVE PERMISSION TO RECEIVE TREATMENT FROM CERTIFIED AND LICENSCED PROFESSIONALS OF HEALING ELEMENTS DAY SPA. I REALIZE THAT THE TREATMENT IS BEING GIVEN FOR THE WELL-BEING OF MY MIND AND BODY. I AGREE TO COMMUNICATE WITH MY PRACTITIONER ANY TIME I FEEL THAT MY WELL-BEING IS BEING COMPROMISED. I UNDERSTAND THE RISKS ASSOCIATED WITH MASSAGE, SKIN CARE TREATMENTS, AND BODY SERVICES AND ASSUME RESPONSIBLILITY FOR SUCH TREATMENTS. I UNDERSTAND THAT THE SERVICE STAFF DO NOT DIAGNOSE ILLNESS, DISEASE, OR ANY PHYSICAL OR MENTAL DISORDER; NOR DO THEY PRECRIBE MEDICAL TREATMENT, PHARMACEUTICALS, OR PERFORM SPINAL THRUST MANIPULATIONS. I ACKNOWLEDGE THAT MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATION OR DIAGNOSIS, AND THAT IT IS RECOMMENDED THAT I SEE A PRIMARY HEALTH CARE PROVIDER FOR THAT SERVICE.

I HAVE STATED ALL MEDICAL CONDITIONS THAT I AM AWARE OF AND WILL UPDATE MY SERVICE PROFESSIONAL OF ANY CHANGES IN MY HEALTH STATUS.

I UNDERSTAND THAT HEALING ELEMENTS DAY SPA REQUIRES A 24-HOUR CANCELLATION NOTICE FOR ANY SINGLE SEERVICE AND A 48-HOUR CANCELLATION NOTICE FOR WEEKENDS, MULTIPLE SERVICES OR GROUPS OF 2 OR MORE.

SIGNATURE_____DATE_____

_____DATE_____

PARENT OR GUARDIAN FOR THOSE 17 AND UNDER