

INDULGE SPA

INTAKE FORM

Name:		Date:	Occupation:		
Address:		Phone:	Date of Birth:		
City:	State:	Zip Code:	Email:		
Emergency Contact Name:			Phone:		
How did you hear about us:			Referral Name:		
GENERAL HEALTH					
1. Rate your level of stress: (5 = highest, 1 = lowest) 5 4 3 2 1					
2. List your stress or other stress reduction activities:					
3. Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No					
4. Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No How many cigarettes per day?					
5. Please list any accidents or surgeries in the last 9 months:					
6. Do you have any metal implants, a pacemaker or body piercings?					
7. List the medications you are currently taking:					
MASSAGE THERAPY			GOAL FOR YOUR MASSAGE SESSION		
Have you ever had a professional massage before? If so, when?			<input type="checkbox"/> Relaxation		
What type of pressure do you prefer?			<input type="checkbox"/> Pain Relief		
Is there any area of your body you do not want massaged?			<input type="checkbox"/> Stress reduction		
HEALTH HISTORY					
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Lymph Edema	<input type="checkbox"/> Herpes/Shingles	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Allergies	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Varicose Veins	
<input type="checkbox"/> Rashes	<input type="checkbox"/> Jaw Pain/TMJ	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Constipation	<input type="checkbox"/> Sprains/Strains	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gas/Bloating	<input type="checkbox"/> Headaches	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Spasms/Cramps	
<input type="checkbox"/> Broken/Fractured Bones	<input type="checkbox"/> Pregnancy (___ weeks)	<input type="checkbox"/> Fatigue/Sleep Disorder	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Cancer	
<input type="checkbox"/> Other (explain):					
SKIN CARE					
1. Are you under the care of a dermatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
2. Do you use: <input type="checkbox"/> Accutane <input type="checkbox"/> Retin A <input type="checkbox"/> Renova <input type="checkbox"/> Adapalene <input type="checkbox"/> Other prescription skin products					
3. Have you had a: <input type="checkbox"/> Chemical Peel <input type="checkbox"/> Microdermabrasion <input type="checkbox"/> Botox <input type="checkbox"/> Other resurfacing treatments					
4. Are you currently using any products that contain: <input type="checkbox"/> Glycolic Acid <input type="checkbox"/> Lactic Acid <input type="checkbox"/> Hydroxy Acid <input type="checkbox"/> Vitamin A					
5. Do you have any skin sensitivities or irritants?					
SKIN MAINTENANCE					
Products You Use: <input type="checkbox"/> Soap <input type="checkbox"/> Cleanser <input type="checkbox"/> Toner <input type="checkbox"/> Moisturizer <input type="checkbox"/> Exfoliator <input type="checkbox"/> Masque					
Skin Type: <input type="checkbox"/> Oily/Congested <input type="checkbox"/> Dry/Dehydrated <input type="checkbox"/> Sensitive/Redness <input type="checkbox"/> Acne <input type="checkbox"/> Sunburned					
<input type="checkbox"/> Eczema <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Psoriasis <input type="checkbox"/> Iodine or Shellfish					
Have you been tanning in the last 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What are your skin care goals?					

It is my choice to receive spa therapies. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update Indulge Spa of any changes to my health status. I understand that Aestheticians, Massage Therapists and Manicurists do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal manipulations. I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and that is recommended I see a primary health care provider for that service. 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.

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