Name _____

Address _____

City _____

State _____ **Zip** _____ **Occupation** _____

Email _____ **DOB** ___/___/_____

Phone Number _____ Home Cell Work

Cell Phone Provider _____

How would you like to receive notifications? Cell Phone Email Both

How did you hear about The Sanctuary Spa? _____

Rate your current stress level? (5=Highest 1=Lowest) Circle 5 4 3 2 1

Do you wear contacts? Y or N **Hearing Aid?** Y or N **Do you have?** Metal Implants/Pacemaker

Are you pregnant? Y or N Number of weeks pregnant:_____

List any medications you are currently taking: _____

Please list any accidents/surgeries/illnesses within the last 9 months: _____

_____

Conditions *(circle all that apply)*

Heart Condition	Herpes/Shingles	High or Low Blood Pressure	HIV
Sinus Problems	Varicose Veins	Rashes/Skin Conditions	Blood Clots
Anxiety/Depression	Jaw Pain	Spasms/Cramps	Cancer/Tumors
Diabetes	Headaches	Arthritis	Fatigue/Sleep Problems
Bruise Easily	Hepatitis	Seizures	Claustrophobia

List any known allergies: _____

Waxing Consent *(Please read and initial)*

I am not 1 week prior or currently menstruating _____

I do not have any open lesions or active herpes outbreak _____

I am not prone to ingrown hairs _____

I understand possible waxing side effects may include but are not limited to: Mild-extreme redness, bruising, temporary local swelling, stinging, tenderness, dry or flaking skin, scabbing, lightening or darkening of the skin, pimples and cold sores. Most side effects are temporary and usually subside within 72 hours _____

Have you had a professional massage before? Y or N

What type of pressure do you prefer? Light Medium Firm Deep

Is there any area of your body you do not want massaged? Feet Glutes Pectorals Abdomen

Your goal for your massage sessions is: Relaxation Pain Relief Stress Reduction

The thing I like best in my massage therapist or therapy is: _____

Have you had a professional manicure or pedicure before? Y or N

When was your last one? _____

Do your nails? *(Circle all that apply)* Split Peel Crack Break

Are your nails? Too Soft or Too Hard

Are your cuticles ever? *(Circle all that apply)* Dry Torn Swollen/Red

Does the skin on your hands or feet ever? *(Circle all that apply)* Crack Break Open Bleed

Do you have? *(Circle all that apply)* Open Cuts/Sores Rashes Bruises Hangnails

Tenderness Nail Discoloration Calluses Corns Ingrown Nails Warts Athletes Foot

Have you ever had a fungus or nail infection? Please explain:_____

Are you under the care of a dermatologist? Y or N

Do you or have you used within the last 12 months any of the following? *(Circle all that apply)*

Glycolic/Lactic/Hydroxy Acids Retin A/Renova Hydroquinone/Lightening Agents

Accutane Blood Thinners Tanning Beds (If so, how often _____)

Have you had? *(Circle all that apply)* Chemical Peel Botox Microdermabrasion Laser Treatments

Products you use at home *(Circle all that apply)* Soap Cleanser Toner Serum

Exfoliator Masque Moisturizer Eye Cream Body Scrub Body Lotion

I think my skin is *(Circle all that apply)* Oily Congested Dry Dehydrated Acne Red Sensitive

If I could change anything about my skin it would be? _____

The Sanctuary spa