Spa Botanica

Shoe Size:_____

At Spa Botanica, we are committed to guest satisfaction. Please fill in the following information to the best of your knowledge. This will allow our therapists to customize your services and make professional recommendations to best suit your needs.

PERSONAL INFORMATION

Last Name:	**First Name:**	**Today's Date:**	
Address:	**City:**	**State:**	**Zip Code:**
Email:	**Phone/Text:**	**Occupation:**	
Gender: □F □M	**Birth Date:**	**How did you hear about us?**	**Please silence your cell phone**

HEALTH INFORMATION

Please indicate if any of the following are relevant to your current state of health:

□ Allergies
□ Anxiety/Depression
□ Arthritis, Type:_____
□ Asthma
□ Bacterial or Fungal Infection
□ Blood Clots
□ Body Implants (Metal, Pacemaker, Prosthesis, etc.)
Explain: _____
□ Cancer, Type : _____
Currently in treatment? : _____
□ Chronic Pain, Explain:_____
□ Claustrophobia
□ Cosmetic Fillers (Botox, Collagen, Restylane, etc.)
□ Dentures
□ Diabetes (Type I or II)
□ Epilepsy or Seizures
□ Fibromyalgia
□ Gout
□ Hearing Aids
□ Heart Problems
□ Hemophilia
□ Hepatitis or Herpes
□ High / Low Blood Pressure
□ HIV / AIDS
□ Migraines/Head aches
□ MS
□ Open Sores, Cuts, Warts
□ Poor Circulation
□ Thyroid Condition
□ Taking Accutane
□ Varicose Veins
□ Wear Contact Lenses
□ Smoke
□ Consume Alcohol Regularly
□ Skin Conditions
Explain:_____
□ Other (s) :_____

***For Women Only*:**
□ Trying to become pregnant
□ *Pregnant-# of Weeks:_____
□ Toxemia (Pre-eclampsia)
□ Lactating
□ Menopause

Are you currently under a doctor's care? □No □ Yes, Please Explain:

*Pregnancy requires an additional intake form.

Please list any major injuries or surgeries. Any dislocations? □No □Yes Any broken bones? □No □Yes Please Explain:

Are you currently taking any medications (internal or topical)? □No □Yes, Please Explain:

Do you have any known allergies or sensitivities (fragrance, cosmetic ingredients, medications, food, iodine, latex, etc.)? □No □Yes, Please list:

SKIN & BODY ANALYSIS

Have you ever been diagnosed with any of the following skin conditions?

☐ Acne ☐ Psoriasis ☐ Seborrhea ☐ Skin Cancer
☐ Contact Dermatitis ☐ Eczema/Rash ☐ Rosacea /Hypersensitivity ☐ Other (s):

Tell us about your skin. (check all that apply)

☐ Normal ☐ Combination ☐ Acne/Problematic ☐ Breakouts(occasional) ☐ Rosacea(Very Sensitive)
☐ Dry ☐ Oily ☐ Sensitive ☐ Mature/Aging

Are you currently using any products that contain any of the following ingredients?

☐ Glycolic Acid ☐ Alpha-Hydroxy Acids ☐ Lactic Acid ☐ Vitamin A Derivatives (i.e. retinol)

Massage: **Is this your first massage?** ☐ No ☐ Yes

Swedish: ☐ Light ☐ Medium ☐ Not Sure
Deep Tissue: ☐ Medium ☐ Firm ☐ Not Sure
Hot Stone: ☐ Light ☐ Medium ☐ Not Sure

Do you have tension or soreness in a specific area? ☐ No ☐ Yes
Please, Explain:

Do you have numbness or tingling in a specific area? ☐ No ☐ Yes
Please, Explain:

Are there any areas you would prefer **not** to be worked on? ☐ No ☐ Yes
Please, Specify:

Skincare:

In the past year, have you received treatment from a dermatologist?
□No □Yes, Please Explain:

What are your specific areas of concern and/or skincare goals?

What are your goals for this session?

Signature required on back →

ALL GUESTS PLEASE READ AND SIGN

I understand that all the information provided on this form will remain completely confidential and will not be shared with any third parties. I understand that it is my responsibility to inform Spa Botanica of any changes to the information I have provided above. Because spa treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions completely and honestly. I understand that the spa services I receive at Spa Botanica are provided for the basic purpose of relaxation and relief of muscular tension. I further understand that spa services should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a qualified medical professional for any mental or physical ailment of which I am aware. I understand that Spa Botanica therapists are not qualified to diagnose or treat any illness and that nothing said in the course of treatment should be construed as such. I understand that if I choose to utilize the steam room facilities, I do so at my own risk. If I experience any pain or discomfort during my services, I will immediately inform my therapist(s) so that the treatment can be adjusted to my level of comfort. I understand that any illicit or sexually suggestive remarks or advances I make will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

► **Client Signature:**_____ **Date:**_____

FOR WAXING CLIENTS ONLY

What body parts are we waxing today?

When did you last shave?

When is your menstrual cycle's start date?*

***Because of water retention and for your personal comfort, avoid hair removal two days before your cycle starts and two days after.**

DO YOU HAVE OR ARE YOU PRONE TO?		**HAVE YOU USED ANY OF THE FOLLOWING IN THE LAST 72 HOURS?**	
Ingrown Hairs	☐ Yes ☐ No	Accutane	☐ Yes ☐ No
Scarring	☐ Yes ☐ No	Retin-A	☐ Yes ☐ No
Bumps	☐ Yes ☐ No	Tretinoin	☐ Yes ☐ No
Hyper pigmentation	☐ Yes ☐ No	Differin	☐ Yes ☐ No
Bruising	☐ Yes ☐ No	Alpha-hydroxy acid	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Glycolic Acid	☐ Yes ☐ No
Cold Sores	☐ Yes ☐ No	Scrub or Peel	☐ Yes ☐ No

Do you use a tanning bed? ☐ Yes ☐ No **Have you used other skin thinning medications? If so, which?**

***New use of any of the medications listed above increases the possibility of a reaction. Please inform the esthetician if you have begun taking any new medications since your last session.**

***Please note waxing does have certain side effects such as skin removal, redness, scabbing, swelling, tenderness, hyper pigmentation, and/or pimples.**

***Waxing of soft tissue may cause the skin to tear resulting in the need for stitches. The most common occurrence of this is in a Brazilian bikini wax.**

I have read the above information and if I had any concerns, I have addressed them with my esthetician. I give permission to my therapist to perform the waxing procedure we have discussed and will hold them harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all oral/tropical medications and allergies. Initial _____

I do not hold the esthetician responsible for any of my conditions that were present but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today. Initial _____