



Client Care Information

Name: _____

Mailing Address: _____
Street (or PO Box) City State Zip

Phone: _____ Fax: _____

Cell: _____ Work: _____

Email (please print clearly): _____
Would you like to be included on our email mailing list? Yes No

Birthday: _____ (MM/DD/YYYY) Profession: _____

Are you pregnant? Yes No, If yes, due date: _____

How did you hear about us? Client Email Postcard Website SPA Finder City Search
Advertisement (where?) Walked By Other:
If referred by a client, please provide first and last name of referral.

What services have you received in the last six months?

Message Facial Manicure Pedicure Body Wrap Waxing Lash Tinting
Microdermabrasion or resurfacing treatment Botox Other

Why did you choose our spa?

Location Price Services Therapist Other:

Cancellation Policy

Because Tranquility Day Spa is by appointment only your appointment is time reserved exclusively for you and we request that you acknowledge and respect our cancellation policy.

If you need to reschedule or cancel an appointment, we require a minimum of 24-hours notice. If you need to cancel your appointment you need to call the office at (617) 924-1026. If we don't answer, leave your information on our answering service.

Please keep in mind that "No-shows" or last minute cancellations leave our therapist with empty appointment times as well as other guests that can not get in.

Because of this, clients that do not honor their appointments will be charged a cancellation fee as follows:

- * More than 24 hour notice Service will be cancelled at no charge.
* Saturday services, requiring one hour or more, with less than a 24 hour notice will be charged 50% of the service price.
* Spa Party services, in full or in part, will be charged 60% of booked services with less than a 72 hr notice.
* Failure to show without notice 100% of the service price will be charged.

~ Sorry but Email appointment cancellations are not accepted ~

If services are for skin care please also complete the Skin Care form
If services are for massage therapy, please also complete the Massage Therapy form

Thank you, your patronage is most appreciated!

Your Name _____

Do you have any special skin problems pertaining to your face or body? Yes No

If yes, please specify _____

What skin care products do you currently use?

Face: soap cleanser toner moisturizer masque exfoliator eye products

Body: soap shower gel scrubs oil body moisturizer depilatory products self tanner

Have you ever had chemical peels, microdermabrasion or any resurfacing treatments? Yes No

If yes, please specify what treatment and when _____

Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? Yes No

If yes, please specify what prescription and when _____

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

glycolic acid tactic acid exfoliating scrubs hydroxy acid products Vitamin A derivatives (i.e. retinol)

Do you experience skin breakouts? Yes No occasionally

If yes, where are the breakouts located? hairline forehead under eye chin cheeks jaw line

Do you experience oily shine during the day? Yes No occasionally

Do you blush easily when nervous? Yes No

Do you have a tendency to redness? Yes No

Do you suffer from sinus problems? Yes No

Do you experience a burning, itching sensation on your skin? Yes No

Have you ever had a reaction to any of the following?

cosmetics medicine iodine pollen food hydroxy acids animals fragrance

sunscreens Other _____

Do you ever experience these conditions on your skin? flakiness tightness obvious dryness

How much plain water do you consume daily? _____

What are your skin care goals?

Your Name: _____

Have you ever had a professional massage? ___ Yes ___ No

Primary reason for a massage: ___ Stress Reduction ___ Muscular Tension ___ Relaxation Other: _____

What is your occupation? _____

Rate your normal stress level: 1 (low) to 10 (high) _____

List your primary areas of discomfort or tension: _____

Are you pregnant? ___ Yes ___ No If yes, due date: _____

Do you exercise or regularly participate in sports? ___ Yes ___ No

If yes, describe the activities and frequency: _____

Rate your general health: ___ Excellent ___ Good ___ Fair ___ Poor

Do you eat a balanced diet? ___ Yes ___ No

Rate your general consumption of the following:

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you been hospitalized in the last year? ___ Yes ___ No If Yes, describe: _____

Please check any conditions you have:

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Circulatory Problem | <input type="checkbox"/> Contagious Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Muscular Injuries |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Skeletal Injuries | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Spinal Problems | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Other _____ |

Please check any chronic symptoms you have:

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Other: _____ | |

Do you wear: ___ Contacts ___ Dentures ___ Prosthesis Other: _____

I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulation. It has been made very clear that massage therapy is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Your Signature: _____ Date: _____