



Client Care Information

Name: _____

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

Phone: _____ Cell: _____

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

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

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. _____

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

Are you pregnant? ____ If yes, due date: _____ Is your pregnancy considered high risk? _____

Do you have any special skin problems pertaining to your face or body? ____ Yes ____ No
If yes, please specify _____

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

Do you suffer from sinus problems? ____ Yes ____ No

Please list any allergies: _____

Have you seen a specialist for any nail infection or fungus? ____ Yes ____ No If yes, when: _____

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

Please check any conditions you have:

- Allergies
- Arthritis
- Blood Clots
- Carpal Tunnel Syndrome
- Circulatory Problem
- Contagious Disease
- Diabetes
- Heart Disease
- High Blood Pressure
- Joint Problems
- Low Blood Pressure
- Muscular Injuries
- Respiratory Problems
- Skeletal Injuries
- Skin Problems
- Spinal Problems
- Varicose Veins
- Other _____

Estheticians, Massage Therapists and Nail Technicians are certified, licensed professionals whose primary concern is to provide superior care for their patrons. Through education and training they are on the look-out for any potential health concerns, such as a suspicious mole, an unexplained skin rash or nail fungus. Since they are not doctors and cannot diagnose, they can only state their concerns and recommend the advice of a physician.

Please be advised that if any contagious disease is noticed or suspected, services will stop at that moment and it will be explained to you that you need to see a Dr. This may be an uncomfortable conversation for both parties, however, please remember, we have your best interests at heart. I have stated all of my known medical conditions and take it upon myself to keep Tranquility updated on my physical health.

Your Signature: _____ Date: _____

Your Name _____

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 _____

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

glycolic acid lactic 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?

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Massage Therapy

Your Name: _____

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

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

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

List your primary areas of discomfort or tension: _____

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

If yes, describe the activities and frequency: _____

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 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: _____	

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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: _____