HEALING HANDS NATURAL THERAPY SPA

NAME: _____ DOB: _____

Address:_____ City: _____ State: _____ Zip:_____

Mobile Phone: _____Mobile Provider:_____ **Okay to text reminders? YES or NO**

Healing Hands Spa will **NOT share personal information such as address, phone numbers, or email address. **

Add E-mail address to receive our news, coupons, and special offers:_____

How did you hear about us: Internet / Chiropractor / Event / Walk-In / Event / Friend: Who? _____

Emergency Contact Name: _____ Phone number:_____

MEDICAL HISTORY

Do you currently see a chiropractor? **YES or NO** Last adjustment: _____

Are you currently under medical supervision**? YES or NO** If yes, please explain: _____

Please list any current medications or the purpose of taking such medications:_____

_____

Please check any condition listed below that applies to you:

___ *Pregnant *If pregnant, how many months? _____ Weeks: _____ Due Date: ___/___/_____

___ Auto-Immune Disorder ___ Fibromyalgia ___ Allergy to Scents/Oils ___ Contagious Skin Condition ___ Diabetes

___Neuropathy Pain/Discomfort: ___ Neck ___ Mid Back ___ Low Back ___ Abdominal ___ Headaches or Migraines

___ Poor Rotation ___ Disc Problems ___ Pinched Nerves ___ Broken Bones ___ Joint Ache ___ Arthritis ___ Sprains

___ Heart Condition ___ High Blood Pressure ___ Stroke ___ Blood Clots ___ Easy Bruising ___ Varicose Veins

___ Osteoporosis/Osteopenia Replacements: __Knee __Hip __Shoulder ___ Other Surgeries: _____

___ Wear Prosthesis ___ Dermal/ Electronic Implants Accident: ___Car ___Fall ___ Whiplash ___ Seizures / Epilepsy

___ Depression / Anxiety ___ Cancer: _____ ___Currently in Treatment: _____

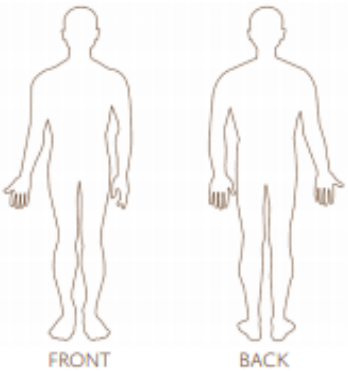
MASSAGE THERAPY

What type of pressure do you prefer? **Light or Firm**

Have you ever received massage therapy before? **YES or NO** **If YES**, when was last massage? _____

Favorite area massaged? _____ Least favorite? _____

All parts of the client's body may be massaged but will not include the male and female genitals and female breasts. Any areas of the body that the client wishes to be avoided during the massage session, or that may need to be avoided due to a contraindication will be listed below. Any areas of the body that either the client or the therapist considers needing additional massage therapy may be indicated below. **Draping will be maintained throughout the session**. At any point a guest is uncomfortable, they may request to stop the service, or the therapist can adjust pressure or change technique.



Please mark, with an 'X', any areas of pain, tightness or spasm.

Areas of the body to be avoided: _____

Areas of the body requiring additional therapy: _____

Massage Therapist Notes:

_____

SKIN CARE / WAXING / SPRAY TAN

Are you currently under the supervision of a dermatologist? **Yes or No**

What type of pressure do you prefer? **Light or Firm** Do you use a tanning bed? **Yes or No**

What is your specific concern about your skin? _____

What skin care products are you currently using at home?

_____

Are you using any other skin thinning products and / or drugs? **Yes or No**

Have you used any Retinol, Alpha Hydroxy Acid (AHA) or Glycolic products in the past 48-72 hours? **Yes or No**

Please check if you are or have experienced any of the following:

___ Skin Cancer ___ Rosacea ___ Enlarged Pores ___ Acne / Breakouts

___ Dermatitis ___ Broken Capillaries ___ Fine lines / Wrinkles ___ Hyperpigmentation

___ Allergic Reaction to a Cosmetic Product, ***If YES***, *please list*: _____

Please check if you are presently using or have used any of the following:

___ Benzoyl Peroxide ___ Salicylic Acid ___ Renova / Retin A ___ Fillers ___ Microdermabrasion

___ Glycolic Acid ___ Resorcinol ___ Botox Injections ___ Light Treatments ___ Facial / Cosmetic Surgery

___ Lactic Acid ___ Accutane ___ Collagen Injections ___ Laser Resurfacing ___ Dermaplaning

Are you exposed to the sun daily or are you considering spending more time in the sun soon? **Yes or No**

PLEASE note that waxing could have certain side effects such as skin removal, redness, swelling, and tenderness.

MANICURES / PEDICURES

Are you currently seeing a Podiatrist? **Yes or No** If yes, please explain: _____

___ Previous conditions treated by a Podiatrist **If yes**, please list condition(s): _____

Please check any condition listed below that applies to you:

___ Ingrown toenails ___ Fungus ___ Thickening of toenails or fingernails ___ Sensitive skin ___ Varicose Veins

___ Sensitive cuticles ___ Pain in feet or ankles ___ Swelling in feet or ankles ___Swelling around fingernails or toenails

What type of pressure do you prefer? **Light or Firm**

I, the client, understand that the service I receive is provided for the basic purpose of relaxation and relief of muscular tension. I understand that massage therapy is a therapeutic health aid **and is non-sexual in any nature**. I understand that Massage Therapists cannot diagnose illness, disease, or any other medical, physical, or emotional disorder and they are **not a substitute for medical care**. I understand that some skin conditions may require more than one treatment and home care products to achieve the result I desire. Results cannot be guaranteed due to individual skin types and conditions. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep all providers updated as to any changes in my medical profile and understand that there shall be no liability on the providers part should I fail to do so. **Client Signature**: _____ Date:_____

Consent to Treatment of Minor Under the Age of 17: By my signature below, I hereby authorize a Licensed or Registered Therapist to administer massage, facial, manicures and pedicures to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____