



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				
Today's Date:		Is your Cell Phone Off? <input type="checkbox"/> Yes <input type="checkbox"/> No		How Did You Hear About Us?
Last Name:	First Name:		Middle:	Gender: F M
DOB: / /	Address:	City:		State:
Zip:	Home Phone:( )	Cell:( )	Emergency Contact:( )	
E-mail:		Occupation:		
HEALTH INFORMATION				
Please indicate if any of the following are relevant to your current state of health:				
<input type="checkbox"/> Anxiety or Depression	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bacterial/Fungal Infection	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Metal, Pacemaker, Prosthesis, Etc.	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chemotherapy/Radiation	<input type="checkbox"/> Chronic Back Pain	<input type="checkbox"/> Claustrophobia
<input type="checkbox"/> Cosmetic Fillers (Botox, Collagen, Restylane, etc.)	<input type="checkbox"/> Dentures	<input type="checkbox"/> Diabetes (Type I or II)	<input type="checkbox"/> Enzyme or Acid Peel	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hepatitis or Herpes	<input type="checkbox"/> High / Low Blood Pressure
<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Laser Resurfacing	<input type="checkbox"/> Open Sores, Cuts, Warts	<input type="checkbox"/> Microdermabrasion	<input type="checkbox"/> Migraines
<input type="checkbox"/> Photo Sensitivity	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Taking Accutane
<input type="checkbox"/> Waxing services	<input type="checkbox"/> Wear Contact Lenses	<input type="checkbox"/> Smoke	<input type="checkbox"/> Consume Alcohol Regularly	<input type="checkbox"/> Other(s):
				<i>For Women Only:</i>
				<input type="checkbox"/> Trying to become pregnant
				<input type="checkbox"/> Pregnant - # of Weeks: ____
				<input type="checkbox"/> Toxemia
				<input type="checkbox"/> Lactating
				<input type="checkbox"/> Menopause
				<input type="checkbox"/> IUD, IUC, etc.
Are you currently under a doctor's care? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please Explain:				
Have you undergone surgery in the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please Explain:				
Are you currently taking any medications (internal or topical)? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please List:				
Do you have any allergies (cosmetic ingredients, medications, food, iodine, latex, fragrance, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please List:				
SKIN & BODY ANALYSIS				
Have you ever been diagnosed with any of the following skin conditions?				
<input type="checkbox"/> Acne	<input type="checkbox"/> Eczema / Rash	<input type="checkbox"/> Rosacea / Hypersensitivity	<input type="checkbox"/> Skin Cancer	
<input type="checkbox"/> Contact Dermatitis	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Seborrhea	<input type="checkbox"/> Other(s):	
What is your skin type(s)?				
<input type="checkbox"/> Normal	<input type="checkbox"/> Combination	<input type="checkbox"/> Acne / Problematic	<input type="checkbox"/> Very Sensitive / Rosacea	
<input type="checkbox"/> Dry	<input type="checkbox"/> Oily	<input type="checkbox"/> Sensitive / Breakout	<input type="checkbox"/> Mature / Aging	
Are you currently using any products that contain any of the following ingredients?				
<input type="checkbox"/> Glycolic Acid	<input type="checkbox"/> Alpha-Hydroxy Acids	<input type="checkbox"/> Lactic Acid	<input type="checkbox"/> Topical Antibiotics	<input type="checkbox"/> Vitamin D Derivatives (retinol)
If I begin using any of the above products and do not inform my esthetician prior to hair removal, I am accepting full responsibility for any skin reactions. Therefore, in the unlikely event of any skin irritation I agree not to hold the esthetician and/or Spa Botanica liable or accountable. <span style="float: right;">Initial: _____</span>				
<b>Massage / Bodywork:</b> Have you ever had a massage before? No Yes Please indicate which type of pressure you prefer. __ Light __ Medium __ Firm __ Not Sure  Do you have any specific areas of concern? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please Explain:  Are there any areas you would prefer avoided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please Specify:		<b>Skincare:</b>  In the past year, have you received treatment from a dermatologist? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please Explain:  What are your specific areas of concern and/or skincare goals?  What skin care products are you using at home?		
I understand that all 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 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 and associates are not qualified to diagnose or treat any illness and that nothing said in the course of treatment should be construed as such. 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 also 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.				
<input checked="" type="checkbox"/> <b>Client Signature:</b>			<b>Date:</b>	