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? ☐Yes ☐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:

☐Anxiety or Depression
☐Arthritis
☐Asthma
☐Bacterial/Fungal Infection
☐Blood Clots
☐Metal, Pacemaker, Prosthesis, Etc.
Explain:___________________
☐Cancer
☐Chemotherapy/Radiation
☐Chronic Back Pain
☐Claustrophobia

☐Cosmetic Fillers (Botox, Collagen, Restylane, etc.)
☐Dentures
☐Diabetes (Type I or II)
☐Enzyme or Acid Peel
☐Epilepsy or Seizures
☐Fibromyalgia
☐Heart Problems
☐Hemophilia
☐Hepatitis or Herpes
☐High / Low Blood Pressure
☐HIV / AIDS

☐Laser Resurfacing
☐Open Sores, Cuts, Warts
☐Microdermabrasion
☐Migraines
☐Photo Sensitivity
☐Poor Circulation
☐Seasonal Allergies
☐Thyroid Condition
☐Taking Accutane
☐Waxing services
☐Wear Contact Lenses

☐Smoke
☐Consume Alcohol Regularly
☐Other(s):

For Women Only:
☐Trying to become pregnant
☐Pregnant - # of Weeks:___
☐Toxemia
☐Lactating
☐Menopause
☐IUD, IUC, etc.

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

Have you undergone surgery in the past year? ☐**No** ☐**Yes, Please Explain:**

Are you currently taking any medications (internal or topical)? ☐ **No** ☐ **Yes, Please List:**

Do you have any allergies (cosmetic ingredients, medications, food, iodine, latex, fragrance, etc.)? ☐**No** ☐**Yes, Please List:**

SKIN & BODY ANALYSIS

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

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

What is your skin type(s)?

☐Normal
☐Dry
☐Combination
☐Oily
☐Acne / Problematic
☐Sensitive / Breakout
☐Very Sensitive / Rosacea
☐Mature / Aging

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

☐ Glycolic Acid ☐Alpha-Hydroxy Acids ☐Lactic Acid ☐Topical Antibiotics ☐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. **Initial:________**

Massage / Bodywork:

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 ? ☐No ☐Yes,
Please Explain:

Are there any areas you would prefer avoided? ☐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 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.

☒**Client Signature:____** **Date:___________________________________**