Renew Day Spa Client Profile

Date: ________________________________
Name: ______________________________
Address: ____________________________
City: _____________ St: ___ Zip: _______

Phone: H - ____________ Cell _____________
DOB: __________________________________
E-Mail: _________________________________
Occupation: ____________________________
Referred By: ____________________________

Are you currently under the care of a physician? □ Yes □ No
If so, please describe why: ____
Are you presently taking any medication? □ Yes □ No
If so, please list the prescriptions and any herbal supplements you are taking: __________________
Are you currently pregnant? □ Yes □ No
Please check any conditions you have had in the past 5 years:

___ Heart Disease ___ High Blood Pressure ___ Back Pain ___ Diabetes
___ Arteriosclerosis ___ Emphysema ___ Ulcers ___ Thyroid Problems
___ Asthma ___ HIV Positive/Aids ___ Cancer ___ Osteoporosis
___ Arthritis (Location)__________________ ___ Epilepsy ___ Seizures

Have you been in an accident or suffered any injuries in the last 2 years? If yes, please explain:
____
Please list the areas you feel the therapist needs to concentrate on: ___________________________
Have you ever had a massage before: □ Yes □ No Date of last massage: __________________

Skin Care History

Do you follow any special diet? □ Yes □ No Do you use Retin A? □ Yes □ No
Are you Claustrophobic? □ Yes □ No Do you use Accutane? □ Yes □ No
Do you have any allergies? □ Yes □ No Do you use Glycolic Acid products? □ Yes □ No
Do you smoke? □ Yes □ No Do you get occasional fever blisters? □ Yes □ No
Have you had laser treatments or microdermabrasion? □ Yes □ No
Have you been exposed to sun or tanning beds recently? □ Yes □ No

General Skin Care Information

What is your home skin care regimen? Product Brand? ___________________________________
Do you feel any burning or itching of the skin? □ Yes □ No If yes, specify _________________
Have you had a skin care treatment (facial) before? □ Yes □ No If yes, when: ______________
What type of improvements would you like to see in your skin? _____________________________

Waxing Information

Is this your first wax treatment? □ Yes □ No If no, have you ever had any **adverse** reactions to waxing? Please describe: ____

Please understand there may be discomfort when a wax treatment is performed and some of the following skin conditions may occur: *Flaking *Dryness *Swelling *Redness *Hyperpigmentation *Ingrown Hair
Remember to use sunscreen to protect your skin from burning or hyperpigmenting.

I have read and understood all the above. By signing I hold harmless Renew Day Spa and all employees thereof, in the event of accident or medical emergency.

Client Signature: ____

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