

Renew Day Spa Client Profile

Date: _____

DOB: _____

Name: _____

E-Mail: _____

Address: _____

Occupation: _____

City: _____ St: _____ Zip: _____

How did you hear about us: _____

Phone: H - _____ Cell _____

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:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV Positive/Aids	<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis (Location) _____	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> 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: _____

Revised 8/27/19