

Renew Day Spa Client Profile

Date: _____
 Name: _____
 Address: _____
 City: _____ St: _____ Zip: _____
 Cell Phone # _____
 DOB: _____
 E-Mail: _____
 Occupation: _____

Who can we thank for referring you?
 How did you hear about us?

Circle One:

Instagram
 Facebook
 Google+
 X
 LinkedIn
 Nextdoor
 TikTok
 Renew Day Spa Logo

Name of friend or family member: _____

Are you currently under the care of a physician? Yes No
 If so, please describe why: _____
 Have you been cleared by your Physician for today's visit? Yes No
 Are you presently taking any medication? Yes No Blood thinners? Yes No
 Medication: _____ Allergies: _____
 Are you currently pregnant? No Yes- how far along? _____
 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
 Hearing Impaired?
 In the last 7 Days COVID or Variant or been exposed to your knowledge?

Massage Care History

Have you been in an accident or suffered any injuries that we should know about? If yes, please explain. Date: _____
 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 the sun or tanning beds recently? Yes No
 Have you ever had a facial before? Yes No Date of last facial? _____

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: _____