

Inner Essence Spa Massage and Facial Form

Name: _____ Date Of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Phone(home): _____ (cell) _____ cell carrier: _____

Occupation: _____ Therapist Gender Preference **NO YES** _____

How did you hear about Inner Essence Spa? _____

Have you had a professional massage/facial before? _____

Emergency Contact Info

Name & Relationship: _____ Phone: _____

Are you taking any medications? **NO YES** _____

Previous Surgeries: _____

List anything related to your current health status: _____

Are you under a dermatologists care? **NO YES** If yes, are they aware you are receiving treatment from us? _____

In the last 6 months, have you used any of the following? (circle) Azelex, Differin, Tazarac, Renova, RetinA, Accutane, AHS's If yes, please write the date you used last: _____

Have you had any cosmetic surgery? **NO YES** (date & type) _____

Are you taking birth control pills? **NO YES**

Are you taking hormone replacement therapy? **NO YES**

Do you wear contact lenses? **NO YES**

Do you smoke? **NO YES**

Are you diabetic? **NO YES**

Do you have any allergies to foods, drugs or cosmetics? **NO**

YES _____

Circle what you currently use: cleanser, toner, exfoliant/scrub, mask, serum, moisturizer, sunscreen

Are you affected by or have any of the following? (circle and explain below) Arthritis Anemia

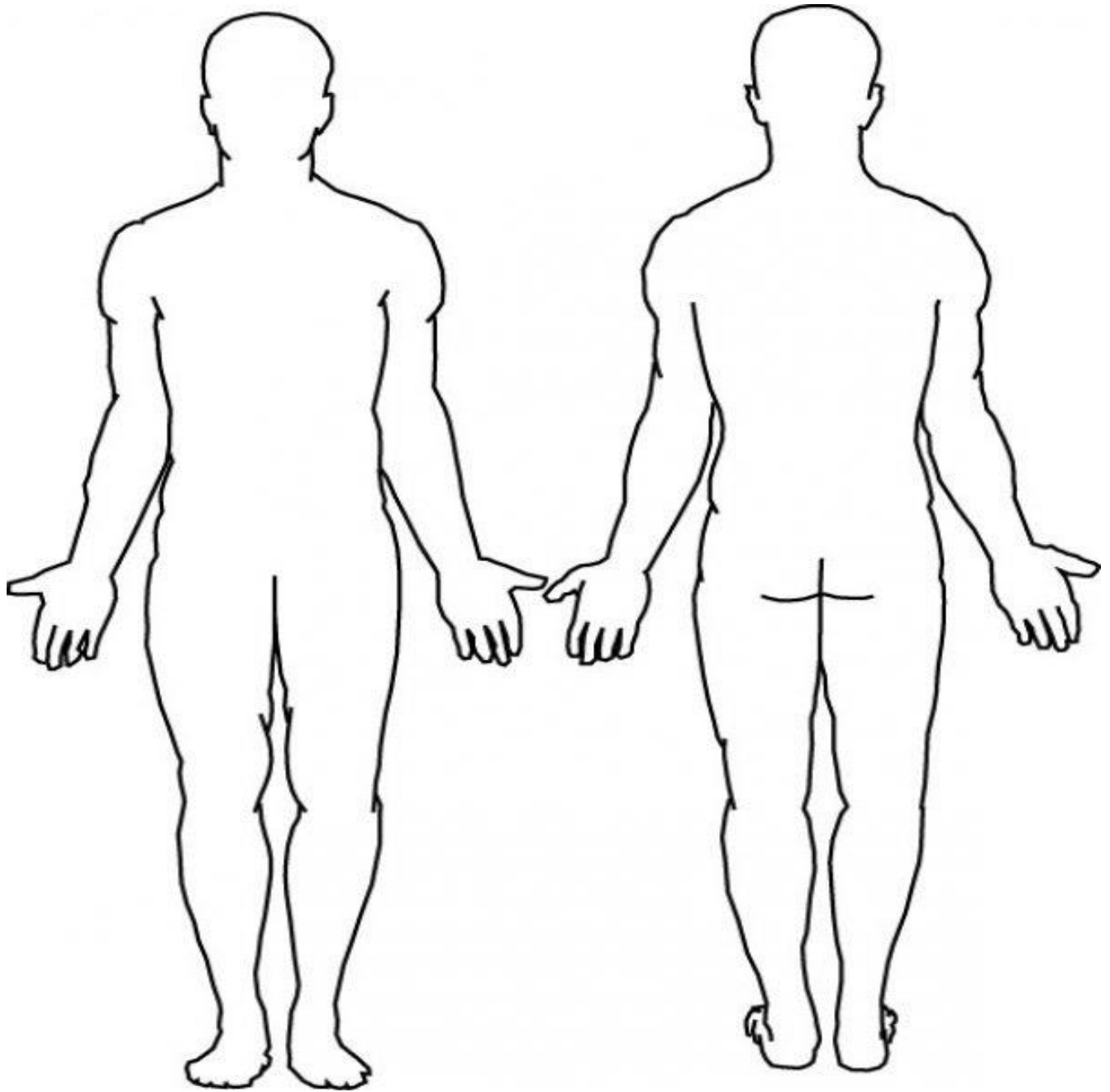
Anxiety Asthma Bursitis Cancer Cardiac/Circulation Problems Blood Clots Depression

Epilepsy Headaches High Blood Pressure Hernia Herpes Joint Problems Metal Pins/Implants

Muscle Sprain/Strain Osteoporosis Pregnancy Pacemaker RA Skin Disease Simplex

Smoker Stress Varicose Veins Vertebral/Disc Problems _____

Please circle on the diagram below where your pain is and where you hold your tension



Inner Essence Spa LLC is not responsible for the aggravation of conditions, which were present, but not disclosed to the practitioner, at the time of service received and which may be affected by the service. Inner Essence Spa LLC is not responsible for any condition, which may/may not have resulted from experiencing services at our facility. By signing, you are stating that you fully understand the above questions and authorize the treatment(s) you are receiving

Signature _____ **Date** _____

If Under 18, Parent/Guardian Signature _____