GUEST INFORMATION FORM

Name _____

Address _____

City _____

State _____ **Zip** _____ **Occupation** _____

Email Address _____ **Birthday** _____/_____

Phone Number _____ **Home** **Cell** **Work**

Cell Phone Provider _____

How would you like to receive notifications? **Cell Phone** **Email** **Both**

How did you hear about The Sanctuary Spa? _____

Rate your current stress level (5=Highest 1=Lowest) **Circle** **5** **4** **3** **2** **1**

Do you wear contacts? Y or N **Hearing Aid? Y or N** **Do you have? Metal Implants/Pacemaker/Piercings**

Are you pregnant? Y or N **Do you smoke? Y or N** **Do you exercise? Y or N**

Approximate # of glasses of water you drink per day _____

List any medications you are currently taking _____

Please list any accidents/surgeries/illnesses within the last 9 months _____

_____

(Circle Condition if Yes)

Heart Condition	**Herpes/Shingles**	**High or Low Blood Pressure**	**HIV**
Sinus Problems	**Varicose Veins**	**Rashes/Skin Conditions**	**Blood Clots**
Anxiety/Depression	**Jaw Pain**	**Spasms/Cramps**	**Cancer/Tumors**
Diabetes	**Headaches**	**Arthritis**	**Fatigue/Sleep Problems**
Bruise Easily	**Hepatitis**	**Seizures**	**Claustrophobia**

List any known allergies _____

Please read and initial the following items:
I am not 1 week prior or currently menstruating _

I do not have any open lesions or active herpes outbreak at this time _____

I am not prone to ingrown hairs _____

I understand possible waxing side effects may include but are not limited to: Mild-extreme redness, bruising, temporary local swelling, stinging, tenderness, dry or flaking skin, scabbing, lightening or darkening of the skin, pimples and cold sores. Most side effects are temporary and usually subside within 72 hours _____

Have you had a professional massage before? Y or N

What type of pressure do you prefer? Light Medium Firm Deep

Is there any area of your body you do not want massaged? (Circle) Feet Glutes Pectorals Abdomen

Your goal for your massage sessions is Relaxation Pain Relief Stress Reduction

The thing I like best in my massage therapist or therapy is _____

Have you had a professional manicure or pedicure before? Y or N

If so, how frequently do you like to get them? _____

When was your last one? _____

What homecare products do you use on your hands, feet and nails? _____

Do your nails? (Circle all that apply) Split Peel Crack Break

Are your nails? Too Soft or Too Hard **Are you ticklish?** Y or N

Are your cuticles ever? (Circle all that apply) Dry Torn Swollen Red

Does the skin on your hands or feet ever? (Circle all that apply) Crack Break Open Bleed

Do you have? (Circle all that apply) Open Cuts/Sores Rashes Bruises Hangnails

Tenderness Nail Discoloration Calluses Corns Ingrown Nails Warts Athletes Foot

What do you want to improve on your hands, feet and nails? _____

Have you ever had a fungus or nail infection? Please explain _____

Are you under the care of a dermatologist? Y or N

Do you or have you used within the last 12 months any of the following? (Circle all that apply)
Accutane Glycolic/Lactic or Hydroxyacids Rein A/Renova Hydroquinone or Lightening Agents

Blood Thinners Tanning Beds (If so, how often _____)

Have you had? (Circle all that apply) Chemical Peel Botox Microdermabrasion Laser Treatments

Do you have any known skin allergies or irritants? _____

Products you use at home (Circle all that apply) Soap Foam or Cream Cleanser Toner

Exfoliator Masque Moisturizer Eye Treatments Body Wash Body Scrub Body Lotion

I think my skin is (Circle all that apply) Oily Congested Dry Dehydrated Acne Red Sensitive

If I could change anything about my skin it would be? _____

The Sanctuary spa