medspa810

Welcome!

Please help us to customize your Facial and/or Massage Experience:

First & Last Name: _____

Date of Birth: _____

Cell Phone#: (_____) _____-_____ Other Phone # H or W ( ) - _____

Street Address, City, Zip: _____

In Case of Emergency, Call: _____ (name & ph#)

Email Address: _ I'd like to receive email specials? Y/N

What brings you in today? Circle any that apply:
(Health & Relaxation) (Look better) (Stress) (Pain) (Headaches) (Pregnancy) Other_____

Health History (note any that apply):

Allergies:_____ Arthritis:_____
Blood Pressure Conditions:_____ Chronic Pain:_____
Headaches:_____ Fibromyalgia:_____
Heart Problems:_____ Heat Sensitivities:_____
Infections:_____ History of Stokes:_____
Insomnia:_____ Immune system deficiencies:_____
Lupus:_____ Medications:_____
Pain, numbness, tingling:_____ Skin Conditions:_____
Surgeries:_____ Vericose Veins:_____
Other:_____
Current Pregnancy_____ **Cancer**_____

FACIAL: To help provide a safe & comfortable experience, check all that apply & explain:

- **Current & past skincare treatments/services:**
- Oral/topical prescription medication:
- Accutane (when?):
- Facial waxing:
- Injectables/dermal fillers:
- Chemical peels/photofacials:
- Microdermabrasion:
- Laser treatments (hair reduction or IPL):
- Facial cosmetic surgery:

Select all past reactions/allergies that apply:

Cosmetics:_____ Iodine:_____
Enzymes:_____ Medication:_____
Foods:_____ Salicylic/glycolic/lactic acid:_____

Fragrance:_____ Sunscreens:_____
Other:_____

What are your skin care problem areas? (circle all that apply)

Tendency towards redness
Sunburn/blush easily
Skin Breakouts
Oily during the day
Sun damage
Aging Skin-fine lines/wrinkles
Dry skin

What are your skincare goals?_____
Do you have a daily skincare regimen? Yes or No
Current Products you use: Vitamin A/Retinol derivatives Exfoliating scrubs Glycolic/lactic acid Hydroxyl acid products

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MASSAGE: To help provide a safe & comfortable MASSAGE experience, please check all that apply & explain:

What are you wanting to accomplish by the end of your massage session:
_____

Are you comfortable with having therapeutic massage on the following areas?
Gluteal region: Y/N Pectoral muscles: Y/N Scalp: Y/N Face: Y/N Abdomen: Y/N Feet: Y/N

Desired massage pressure (circle one): LIGHT MEDIUM DEEP

Are you experiencing pain in the following areas? Using scale of 1-10 (1=lowest & 10=highest pain level)
NECK:_____ BACK:_____ LEGS:_____ SHOULDER:_____ ARMS:_____ OTHER:_____

CLIENT CONSENT

It is your responsibility to inform the aesthetician/therapist/technician/practitioner of any pre-existing conditions, limitations, or specific sensitivities and to inform your aesthetician/therapist/technician/practitioner if you feel any discomfort during the session. If you do experience discomfort, please communicate to adjust the process. You understand and voluntarily accept any risks which you have been advised about associated with your any treatment you receive, or from any use of the company's facilities, services, or products and you hereby release Scottsdale Vitality Medspa LLC (DBA medspa810 North Scottsdale), including its employees, practitioners, agents and insurers, from all liability for any injury, including, without limitation, personal, bodily or mental injury, economic loss or any damage to you resulting therefrom. You further hereby release all of the foregoing personnel and entities from all liability arising from any such injury or damage resulting from your failure to disclose any pre-existing condition, limitation or specific sensitivities, or your failure to inform your aesthetician/therapist/technician/practitioner of any discomfort during the session. Your aesthetician/therapist/technician/practitioner may determine that it is unsafe for you to proceed with or continue treatment due to health related concerns/contraindications. In this event you may be required to provide medspa810 with a physician's medical release prior to continuing treatment. The undersigned acknowledges that they have read this agreement.

Signature:_____ **Date:_____**

FOR DEPENDENT CONSENT: my signature below authorizes medspa810 to administer treatment to my minor child or dependent according to the consent paragraph above: Name of Minor Child:_____

Parent/Guardian Signature:_____ Date:_____