

GENERAL INFORMATION					
Name:		Today's Date:		Occupation:	
Address:		City:		Province:	Postal Code:
Phone #:		Date of Birth:		Email:	
Emergency Contact:			Phone #:	How did you hear about us?	
Preferred Method of Communication:		<input type="checkbox"/> Email	<input type="checkbox"/> Phone	Name of Person Who Referred You:	
GENERAL HEALTH					
Rate your level of Stress (1 = lowest; 5 = highest): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5					
What physical activities do you enjoy?					
Do you wear contact lenses?		<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you claustrophobic?		
			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Please list any accidents or surgeries in the past 12 months: (if you have had surgery in the past 12 months)					
Do you have? Metal Implants		<input type="checkbox"/> YES <input type="checkbox"/> NO	Pace Maker		<input type="checkbox"/> YES <input type="checkbox"/> NO
				Body Piercings	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
List any medication(s)/supplement(s) you are taking:					
Are you currently taking?		<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Birth Control	<input type="checkbox"/> Hormone Replacement	<input type="checkbox"/> Blood Thinners
HEALTH HISTORY – Please check here if none apply <input type="checkbox"/>					
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Facial Warts	<input type="checkbox"/> Herpes Simplex Virus	<input type="checkbox"/> MRSA	<input type="checkbox"/> Citrus Allergy	
<input type="checkbox"/> Rosacea	<input type="checkbox"/> Sun Burn/Allergy	<input type="checkbox"/> Eye Infection/Disorder	<input type="checkbox"/> Smoker	<input type="checkbox"/> Sulfates/Sulfur Allergy	
<input type="checkbox"/> Lupus/Autoimmune	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sciatica	
<input type="checkbox"/> Soy Allergy	<input type="checkbox"/> Wheat Allergy	<input type="checkbox"/> Nut Allergy	<input type="checkbox"/> Seaweed Allergy	<input type="checkbox"/> Eczema	
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Other				
Have you ever been diagnosed with Cancer?			<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you pregnant or trying to become pregnant?	
				<input type="checkbox"/> Yes <input type="checkbox"/> NO	
Any other medical conditions or concerns we need to know about? Explain:					
SKIN CARE					
Are you currently under the care of a Dermatologist?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
Do you use any of the following topical products?		<input type="checkbox"/> Accutane	<input type="checkbox"/> Retin A/Stiva A	<input type="checkbox"/> Isotretinoin	<input type="checkbox"/> Adapalene
		<input type="checkbox"/> Vitamin C	<input type="checkbox"/> Tretinoin/Avita	<input type="checkbox"/> Scrub/Peel	
<input type="checkbox"/> Other prescription topical skin products. Please be specific:					
Have you had any of the following?		<input type="checkbox"/> Chemical Peel	<input type="checkbox"/> Botox	<input type="checkbox"/> Microderm	<input type="checkbox"/> Dermal Filler
				<input type="checkbox"/> Permanent Cosmetics	
<input type="checkbox"/> Other resurfacing treatments. Please be specific:					
Any serious side effects?		<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, please specify:		
Are you currently using any products that contain the following?		<input type="checkbox"/> Glycolic Acid	<input type="checkbox"/> Lactic Acid	<input type="checkbox"/> Hydroxy Acid	<input type="checkbox"/> Vitamin A
				<input type="checkbox"/> Vitamin C	
Have you had an allergic reaction to any waxing or skincare products?			<input type="checkbox"/> YES <input type="checkbox"/> NO	Explain:	
SKIN MAINTENANCE			PRODUCTS USED – List Brand and Frequency of Use		
Skin Condition/Type:	<input type="checkbox"/> Oily/Congested	<input type="checkbox"/> Dry/Dehydrated		Brand	Frequency
<input type="checkbox"/> Sensitive/Redness	<input type="checkbox"/> Acne/Breakouts	<input type="checkbox"/> Sunburned	<input type="checkbox"/> Soap/Cleanser		
Have you been tanning in the last 24 hours?		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> SPF		
In the last week have you had?		<input type="checkbox"/> Waxing	<input type="checkbox"/> Laser	<input type="checkbox"/> Electrolysis	<input type="checkbox"/> Toner
Do you use sunscreen?		<input type="checkbox"/> YES <input type="checkbox"/> NO	If so, what SPF?	<input type="checkbox"/> Exfoliator	
What are your primary skin care goals?		<input type="checkbox"/> Anti-Aging	<input type="checkbox"/> Masque		
<input type="checkbox"/> Sensitivity	<input type="checkbox"/> Acne/Breakouts	<input type="checkbox"/> Brightening/ Lightening	<input type="checkbox"/> Moisturizer		
Comments:			<input type="checkbox"/> Serum		

Please turn over →

Esthetics Client Intake Form

It is my choice to receive spa treatments, including facials, peels, LED, microdermabrasion or hair removal/waxing. I understand that the skin care and waxing program must be used in accordance to the pre/post care instructions and descriptions given to me by the service provider. I understand that I may experience varying degrees of redness, burning, peeling, itching, etc., especially in the initial stages of the treatment program. These symptoms are often normal and will eventually subside as the skin builds tolerance. I understand that it is necessary to maintain the use of the skin care program over the long term in order to retain the benefits obtained in the early weeks of the treatment program. Because facials should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions or answered all questions asked of me honestly. I agree to keep the Esthetician updated as to any changes in my medical profile and understand that there shall be no liability on the Esthetician's part should I fail to do so. I further understand that I am paying for a treatment and not a result and that there will be no returns, refunds or exchanges for product given. Further, I understand that HAND & STONE MASSAGE and FACIAL SPA reserves the right to refuse to administer services at their sole discretion. I have read and fully understand this form in its entirety. If at any time there are changes in the information given, or in my condition, I will notify my Esthetician and update this form before receiving additional facials or waxing.

If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24-hour notice, I agree to pay the missed appointment fee that applies. **Initial Here:** _____

I understand that any illicit or sexually suggestive behaviour, remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled service. Further, I understand that HAND & STONE MASSAGE AND FACIAL SPA reserves the right to refuse to administer services at their sole discretion. I have read and fully understand this form in its entirety. I hereby release the practitioners, Hand & Stone Massage and Facial Spa and their insurers, and their respective officers, directors, stockholders, successors, employees, franchisor and agents from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving massage, skin care (facials, peels), microdermabrasion or hair removal services.

I understand that I may disrobe to my comfort level. Some waxing services require the Esthetician to touch and treat sensitive areas such as breast tissue, genitals, buttocks and inner thighs. I acknowledge that I can withdraw from my service or alter my consent at any time. **Initial Here:** _____

I hereby state that the information I have provided is accurate and true.

Client Signature

Date

Consent to Treatment of Minors: By my signature below, I authorize HAND & STONE MASSAGE AND FACIAL SPA to administer facial / waxing services to my minor child or dependent as they deem necessary or proper.

SIGNATURE: _____

DATE: _____

Esthetician Signature

Date

Hand & Stone Massage and Facial Spas are independently owned and operated franchise locations.