HAND & STONE® MASSAGE AND FACIAL SPA

CLIENT HEALTH HISTORY FORM

Last Updated: _____

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name:	Phone #:
Home Address:	Email Address:
Occupation:	Date of Birth:
Emergency Contact (mandatory) Name: Phone#:	Primary Care Physician: Address:
How did you hear about us?	Are you currently receiving treatment from another health care professional? ☐ YES ☐ NO If YES, for what?

Please indicate conditions you are experiencing or have experienced:

Cardiovascular:
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease

Is there a family history of any of the above?
☐ YES ☐ NO

Respiratory:
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there a family history of any of the above?
☐ YES ☐ NO

Infections:
- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions:
- ☐ Loss of sensation, where?
- ☐ Diabetes, onset:
- ☐ Epilepsy
- ☐ Cancer, where?
- ☐ Skin conditions, what?
- ☐ Arthritis, where?
- ☐ Allergies/Hyper sensitivity to what?
  Type of reaction:

Is there a family history of any of the above?
☐ YES ☐ NO

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness): ☐ YES ☐ NO
Please Specify:

Head/Neck:
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Women:
- ☐ Pregnant, due:
- ☐ Gynecological conditions, what?

Overall, how is your general health?

Do you have any internal pins, wires, artificial joints or special equipment? ☐ YES ☐ NO
What: Where:

Current medications: Condition it treats:	Are you currently taking: ☐ Antibiotics ☐ Blood thinners ☐ N/A ☐ Birth control ☐ Hormone replacement
Please list any surgeries or injuries: Surgery – date: Nature: Injury – date: Nature:	

MASSAGE

Have you received massage therapy before? ☐ YES ☐ NO	What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort or area of focus.
Did a health care practitioner refer you for massage therapy? ☐ YES ☐ NO If yes, please provide their name and address:	***Please Turn Over***

ESTHETICS

Are you currently under the care of a Dermatologist? ☐ YES ☐ NO

Do you use any of the following topical products? ☐ Accutane ☐ Retin A/Stiva A ☐ Isotretinion ☐ Adapalene ☐ Differin ☐ Vitamin C ☐ Tretinoin/Avita ☐ Scrub/Peel ☐ N/A

☐ Other prescription topical skin products. Please be specific:

Have you had any of the following *in the past 2 weeks?* ☐ Chemical Peel ☐ Botox ☐ Microderm ☐ Dermal Filler ☐ Permanent Cosmetics ☐ N/A

☐ Other resurfacing treatments, please be specific:

Any serious side effects? ☐ YES ☐ NO If YES, please specify:

Are you currently using any products that contain the following? ☐ Glycolic Acid ☐ Lactic Acid ☐ Hydroxy Acid ☐ Vitamin A ☐ Vitamin C ☐ N/A

Have you had an allergic reaction to any waxing or skincare products? ☐ YES ☐ NO Explain:

Skin Maintenance	Products Used – List Brand and Frequency of Use		
Skin Condition/Type: ☐ Oily/Congested ☐ Dry/Dehydrated ☐ Sensitive/Redness ☐ Acne/Breakouts ☐ Sunburned		Brand	Frequency
	☐ Soap/Cleanser		
Have you been tanning in the last 24 hours? ☐ YES ☐ NO	☐ SPF		
In the last week have you had? ☐ Waxing ☐ Laser ☐ Electrolysis	☐ Toner		
Do you use sunscreen? ☐ YES ☐ NO If so, what SPF?	☐ Exfoliator		
What are your primary skin care goals? ☐ Anti-Aging ☐ Sensitivity ☐ Acne/Breakouts ☐ Brightening/Lightening	☐ Masque		
	☐ Moisturizer		
Comments:	☐ Serum		

Consent: I understand that the **massage therapy** I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the Massage Therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage therapy is not a substitute for medical examination, diagnosis or treatment and that I should see a physician or qualified medical specialist for any physical or medical ailment of which I am aware. I understand massage therapy should not be performed under certain medical conditions, and I affirm that I have stated all my known medical conditions and have answered all questions accurately.

It is my choice to receive **spa treatments**, including facials, peels, LED, microdermabrasion or hair removal/waxing. I understand that the skin care and hair removal program must be used in accordance with 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 a 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 and have answered all questions accurately. 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 services or products given.

I understand that I may disrobe to my comfort level. I acknowledge that it is my choice of a female or male massage therapist. Some hair removal 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 if I am in any way uncomfortable. Initial Here: _____

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 service provider, and update this form before receiving additional services. I have read and fully understand this form in its entirety. I hereby release the Massage Therapist, Esthetician, 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.

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: _____

My signature below affirms that I have read, agree to the foregoing and the information I have provided is accurate and true.

SIGNATURE: _____ **DATE:** _____

Consent to treatment of minor: By my signature below, I authorize HAND & STONE MASSAGE AND FACIAL SPA to administer massage or bodywork techniques or a facial to my minor child or dependent (name:_____) as they deem necessary or proper.

SIGNATURE: _____ **DATE:** _____