Kneaded Relief Day Spa
Client General Information Form

Name (*First, M.I., Last*)_____ Address_____
City_____ State_____ Zip_____
Age____ Birth Date_____ Sex: M F Height_____ Weight_____ Robe size_____ Shoe size_____
Email (please print clearly) _____
I would like to receive email specials: Yes ☐ No ☐
I would like to receive a monthly e-newsletter: Yes ☐ No ☐
Telephone (home) _____ (cell) _____ (work) _____
How would you prefer appointment confirmations? Phone ☐ (Primary phone: H C W) Email ☐
Occupation _____
Primary Physician_____ Physician's Phone _____
Referred by _____ Phone (if known) _____
Emergency Contact _____ Phone _____

Client Health History:

Please check any of the following conditions that may pertain to you.
The information you give will help us determine the most safe and effective treatment for you.

Do You Have Any Health Issues?

☐ Blood Disorders
☐ Phlebitis/Blood Clot Disorder
☐ Anemia
☐ Heart Problems/Disease
☐ High Blood Pressure (Medication:_____)
☐ Low Blood Pressure (Medication:_____)
☐ Poor Circulation/Cold Hands/Feet (Circle one)
☐ Numbness/Tingling/Twitches (Circle one)
Where?:_____
☐ Thyroid (Circle one: Over or Under Functioning)
☐ Varicose Veins -Diagnosed by Dr? ☐ Yes ☐ No
☐ Psoriasis
☐ Fibromyalgia
☐ Arthritis/Rheumatism - Type: _____
☐ Cancer - Current or Remission?
Type: _____
☐ HIV/AIDS
☐ Hepatitis – Type: _____
☐ Diabetes – Onset: _____
Headaches - Type/Frequency: _____

What is your level of stress?
☐ Modest ☐ Average ☐ Severe
Do you have any implants? ☐ Yes ☐ No
*Pacemaker, Pins in Bones, Etc.*_____
Do you wear: Contact Lenses? ☐ Yes ☐ No
Hearing aids? ☐ Yes ☐ No
Dentures? ☐ Yes ☐ No
Have you undergone treatment from a dermatologist? *If so, for what conditions?*_____
_____

Please list all allergies/sensitivities you have to any product or ingredient (Oils, Nuts, Iodine, etc.):
_____
_____
Recent Injuries:
Type and Date:_____
_____
Recent Surgeries:
Type and Date:_____
_____
Current Symptoms:_____
_____
_____
Do you use tanning beds/sunbathe? ☐ Yes ☐ No
*If Yes, How Often?*_____
Are you pregnant? ☐ No ☐ Yes - Due date: _____
Are you taking birth control pills? ☐ Yes ☐ No
Accutane? ☐ Yes ☐ No
Retin A? ☐ Yes ☐ No
Other current medications (including topical):
Name:_____
_____
For what condition(s):_____
_____
Any contagious diseases (Please List)_____
_____
_____
Is there anything else we should know about your well-being?_____
_____

Kneaded Relief Day Spa
Appointment Contract

Our cancellation policy is as follows:

1. If you must cancel, we ask for 24 hour notification (Monday-Thursday) or 48 hours (Friday-Sunday or with Packages), so that we may offer that appointment to someone on our waiting list.
2. In the event of a cancellation less than the notification time stated above, there will be a charge for 50% of the treatment cost.
3. In the event of a missed appointment ("no show"), there will be a charge for 100% of the treatment cost.

We do understand that emergencies arise and weather conditions may become hazardous. Please call us so that we are aware of your situation.

<u>Kneaded Relief would like to ensure you that your spa day is exactly what you request.</u>

- Please be aware that a consultation with your therapist will be a part of your service and is included within the service time.
- I understand that the various treatments given here are for the purpose of relaxation, stress reduction, relief from muscular tension or spasm, reduction of scar tissue and chronic pain, and for the promotion of circulation, lymph activity, flexibility, and energy flow.
- The therapist must be made aware of any existing physical and mental condition; hence I have stated all my known medical conditions. I take it upon myself to keep them updated on my physical and mental health, conditions and concerns, and understand that there shall be no liability on the therapist's part should I fail to do so.
- I understand that communication is an essential part of my treatment and agree to tell my therapist if I am uncomfortable, want less pressure or need more.
- I also understand that any sexual suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment in full.

By signing below I am agreeing to these terms.

Signature: _____ Date: _____

If you are delighted with your service today, reward yourself by booking your next service and save! Ask for details at Guest Services.

Kneaded Relief Day Spa
Client Massage Form

Name_____

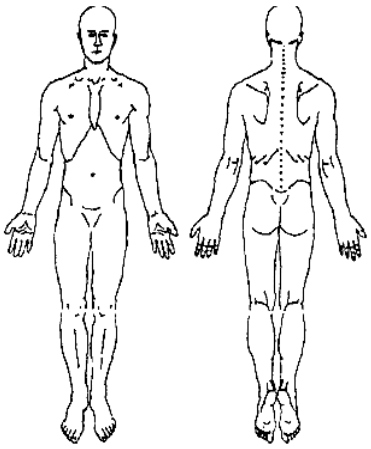
Have you had a professional massage before? Yes ☐ No ☐
Do you have any difficulty lying on your ☐ front, ☐ back or ☐ side?
If yes, please explain: _____
Do you sit for long hours at a workstation, computer, or driving? Yes ☐ No ☐
Do you perform any repetitive movement in your work, sports, or hobby? Yes ☐ No ☐
Do you see a chiropractor? Yes ☐ No ☐ If yes, how often? _____

Please identify any tight, tense, or sore areas or areas of chronic muscular pain that you would like the therapist to address. You may also mark them on the figures below:

Muscles/Joints
Circle one: Pain/Stiffness/Spasms

	Current	Previous
Neck	_____	_____
Low Back	_____	_____
Mid Back	_____	_____
Upper Back	_____	_____
Shoulders	_____	_____
Left/Right Leg	_____	_____
Left/Right Knee	_____	_____

Please explain _____
_____



Please *check* any of the following conditions that may pertain to you.
The information you give will help us determine the most safe and effective treatment for you.

( ) Insomnia
( ) Chronic Fatigue
( ) Depression/Anxiety
( ) Difficult Digestion/Constipation
( ) Bruise Easily
( ) Skin Conditions:
Type:_____

( ) Earaches
( ) Jaw Pain/TMJ
( ) Osteoporosis
( ) Sciatica
( ) Paralysis
( ) Seizures
( ) Parkinson's Disease

( ) Menstrual Problems/PMS
( ) Menopausal Problems?
( ) Breast Tenderness

( ) Smoker ___Past ___Present
( ) Sinus
( ) Chronic Cough
( ) Frequent Colds
( ) Shortness of Breath/Asthma
( ) Other Breathing Problems
Type:_____

( ) Spinal Problems
Type:_____
( ) Multiple Sclerosis

( ) Foot Problems
___Athletes Foot
___Warts
___Bunions
( ) Prosthesis
___Pins
___Limbs

If necessary, please explain any condition that you have marked above:_____
_____
_____

Kneaded Relief Day Spa

Client Treatment Form

Facials/Body Treatments/ Waxing /Nail Services

Name_____

Please fill out all checked sections below:

☐ Facial/Body Treatment

Diet -- Check All That Apply
☐ I take Nutritional Supplements _____
☐ I take vitamin supplements daily (Please List)_____ _____
☐ I eat "junk food" often
☐ I smoke

	Yes	No
Are You Using Alpha-Hydroxy Acids/Fruit Acids?		
Have You Ever Had An Adverse Reaction To A Cosmetic Product?		
*If so, which product or ingredient?*_____ _____ _____		

☐ Facial

Is Your Skin Sensitive? ☐ Yes ☐ No

What Are You Currently Using for Your at Home Facial Care? _____

_____

_____

_____

Do You Have Any Diagnosed Skin Conditions?

*If so, describe?*_____

_____

What Medications Are You Using to Treat the condition(s)? _____

_____

☐ Body Treatment

What Results Would You Like to See From Your Service?_____

_____

_____

Do You Suffer From:

☐ Back Problems ☐ Dry, Flaky Scalp

☐ Dry Skin ☐ Dry, Damaged Hair

☐ Cellulite

What Products Do You Currently Use?

☐ Soaps ☐ Shower/Bath Gel

☐ Body Scrub ☐ Body Lotion/Crème

☐ Sun Protection ☐ Self-Tanner

☐ Other_____

Which Body Areas Are Of Concern To You?_____

_____

Why?_____

_____

☐ Waxing

Is this your first hair removal treatment? ☐ Yes ☐ No

If no, have you ever experience bruising due to a treatment? ☐ Yes ☐ No

Have you undergone microdermabrasion in the past month? ☐ Yes ☐ No

Please indicate below the date of your most recent: Chemical Peel _____ Waxing _____

Please indicate whether you have any of the following conditions or if you are taking any of the following medications: _____ Cortisone _____ Tetracycline _____ Renova/Differin (in the last month)

_____ Dermal Abrasions _____ Warts/Herpes _____ Eczema _____ Rosacea

☐ Nail Service

Have you ever worn artificial nails?_____

If yes, which type? Acrylic, Silk Wraps, Gel Caps, Fiberglass, Other_____

Did you ever experience a problem with these?_____

If yes, explain:_____

Do you currently have problems with your nails/skin? (Weak, Brittle, Fungus, etc)

Please explain:_____

What improvements would you like to see with regard to your nails and hands/feet?_____

_____