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Fitchburg, WI 53711
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KNEADEDRELIEFDAYSPA.COM

Madison's First and Only
Destination Wellness Spa

CONFIDENTIAL CLIENT INFORMATION - FACIAL

Name:__________________________________ Date of Birth:__________________________
Address:______________ City:__________________ State:________ Zip:____________
Phone Number (home)________________ (cell)________________ (work)____________
Email Address:____
Current Occupation:____
Height: ____________ Weight________ Shoe Size:________ Robe Size: __________
How did you hear about us? ______________From a Friend, provide his/her name: ______________
Confirmation preference (please circle): Home Cell Email Work
Emergency Contact:________________Primary Physician & Phone:________________
Have you ever received a professional skincare treatment? Yes or No How recently?______________
What type of treatment did you receive? (please circle)
Relaxing Facial Acne/Deep Cleansing Facial Anti-Aging Facial Microdermabrasion Light/Laser Therapy
Other, please explain:____

THE FOLLOWING REQUIRED INFORMATION MUST BE COMPLETED IN ITS ENTIRETY, HONESTLY AND TO THE BEST OF YOUR KNOWLEDGE:

Please list ALL medications (over-the-counter and prescribed) and supplements that you are currently taking:________
____
Please list all allergies or sensitivities, including scents and essential oils:____________________
____
Do you have or have you recently been in contact with any contagious illnesses or infections, including skin conditions: Yes or No Please explain: ___________________________________
Have you ingested any (**please circle**) alcohol, illegal substances, or anti-inflammatory medication in the last 24 hours? Yes or No
Are you currently pregnant? Yes or No How many weeks?____________ Due Date:______________
MEDICAL INFORMATION: (please circle)

What is your typical daily intake of:				
Water?	None	Light	Moderate	Heavy
Caffeine?	None	Light	Moderate	Heavy
Salt?	None	Light	Moderate	Heavy
Sugar?	None	Light	Moderate	Heavy
Cigarettes?	None	Light	Moderate	Heavy
Dairy?	None	Light	Moderate	Heavy
Spicy Food?	None	Light	Moderate	Heavy

Do you have any of the following occurring today or in the last week (please circle):

cold/flu/fever	bruises, cuts or burns	headache	Cold sores
warts	numbness/tingling	skin rash	sunburn

Do you use a tanning bed or sunbathe on a regular basis? Yes or No
Do you burn easily in the sun? Yes or No
Do you blush/turn red easily? Yes or No
Do you have sensitivity to products? Yes or No
Do you experience problems with any of the following? (please circle all that apply)

Tightness in skin	Flaking Skin	Shiny/oily skin	Scars
Moles	Acne Breakouts	Rough Texture	Broken Capillaries
Wrinkles/fine lines	Dull/Dry Skin	Sun damage	Dehydrated Skin
Whiteheads/Blackheads	Redness	Vitaligo	Hyperpigmentation/Dark Spots

PLEASE CIRCLE ANY HEALTH CONDITIONS BELOW THAT APPLY TO YOU NOW OR IN THE PAST:

Anemia	Depression	Insomnia
Anxiety/Panic Attacks	Diabetes	Jaw Pain/TMJ
Arthritis ___________	Digestion Issues	Knee Pain
Arm/elbow/wrist pain	Eczema	Neck/Shoulder Pain
Asthma	Fainting	Numbness/tingling
Back pain	Fibromyalgia	Osteoporosis
Blood clots	Gout	Pacemaker
Bone Disease or disorder	Headaches/Migraines	Paralysis
Broken Bones	Heart Attack	Post-Traumatic Stress Disorder
Bruise easily	Hearing Aids	Rosacea
Bursitis	Hepatitis:_______________	Sciatica
Cancer:_________	Heart Problems/disease	Scoliosis
Cardiac Problems	High/Low Blood Pressure	Seizures
Circulatory Problems	Hip/Leg Pain	Stroke
Claustrophobia	HIV/AIDS	Surgery:________________
Chronic Fatigue Syndrome	Implants:________________	Thyroid: ________________

Further explanation for any of above conditions or other conditions not listed:______________________________

____

____

Do you have any implants? *Pacemaker, pins on bones, etc.*____

Please list all products used regularly on the area to be treated today:

Soap/Cleanser:__________________ Eye Product:____________________ Night Moisturizer/Cream:_________________

Exfoliator/Scrub: ________________ Day Moisturizer: ________________ Other:_________________

Mask:__________________ Sunscreen: _____________________ Toner:_________________

Are you using or have you used Lactic acid, glycolic acid, salicylic acid, Retinol, or any doctor prescribed acne/anti-aging creams, gels, or medications (topical or oral) or over the counter products? Yes or No

Please describe:____

Have you undergone treatment from a dermatologist? *If so for what conditions?*______________________________

____

If you are still undergoing treatment and if not when was the last treatment?____________________________

What are your specific concerns/goals for your skincare treatments? ___________________________________

____

____

Cancellation Policy: If you must cancel we ask for a 48 hour notice, so that we may offer that appointment to someone on our waiting list. In the event of a cancellation less than 48 hours, there will be a charge for 50% of the treatment cost. 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. Kneaded Relief would like to ensure you that your spa visit is exactly what you request. Please be aware that a consultation with your therapist will be a part of your service and is included within the service time. 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 or Kneaded Reliefs part should I fail to do so. I understand that certain medical issues may contraindicate massage services and will be referred to a medical professional. 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:_____________________________

I consent to the taking of photographs to monitor treatment effects as desired/recommended by my therapist.______ (initial)