5500 E Cheryl Pkwy Ste. 126
Fitchburg, WI 53711
608-255-0070
KNEADEDRELIEFDAYSPA.COM

Madison's First and Only
Destination Wellness Spa

CONFIDENTIAL CLIENT INFORMATION

Name:_____ Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone Number (home)_____ (cell)_____ (work)_____
Email Address:_____
Current Occupation:_____ Primary Physician & Number:_____
Height: _____Weight_____Shoe Size:_____Robe Size: _____
How did you hear about us? _____ From a Friend, please provide his/her name: _____
Emergency Contact: _____
Confirmation preference (please circle): Home Cell Email Work

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:_____

_____

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

Please list any medications and supplements that you are currently taking: _____

_____

Please list ALL allergies or sensitivities, including smells:_____
Do you have any recent skin conditions: Yes or No If yes, please explain: _____
What is your level of stress? Modest Average Severe
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:_____
Do you have any implants? *Pacemaker, Pin in bones, etc.*_____
Please list any recent injuries/surgeries/car accidents? _____

_____

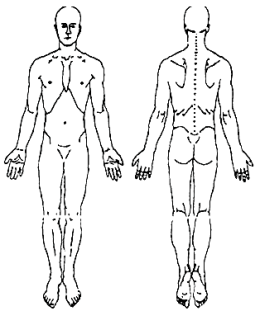
Do you wear (please circle any that apply): contact lenses hearing aids dentures
Do you have any of the following occurring today or in the past week:
cold/flu/fever cuts, bruises, or burns inflammation numbness/tingling skin rash severe pain sunburn
headache: type and frequency:_____
Do you exercise and/or stretch on a regular basis? Yes No How often and what type of workout? _____

_____

BODY TREATMENT: What products are you currently using? (circle)

Soap	shower/bath gel	body scrub	AHAs	Retinols
Sun protection	self-tanner	body lotion/crème	Retin-A	

MASSAGE SERVICE: Please use the illustration to indicate with an **X** any areas of pain, discomfort, or tightness. Use the space below to write any other concerns



NAIL SERVICE: Do you have any condition that could affect service options for example, diabetes or other circulation disorders, slow healing, sensitivity to any cosmetic ingredient, currently pregnant?

Have you ever had or do you now have a nail infection/fungus on either your fingernails or toenails? Yes or No
Please explain:
**If currently yes, we will not be able to proceed with nail service due to WI state sanitation statutes.

Do your nails:	Split	Peel	Crack	Break		
Are your nails:	Too Soft	Too Hard				
Are your cuticles ever:	Dry	Torn	Ragged	Inflamed	Red	
On your hands/feet, do you have:	Calluses	Corns	Ingrown Nails	Warts	Athlete's Foot	
Does the skin on your hands/feet ever:	Crack	Break open	Bleed			
On your hands or feet, do you have:	Open Wounds	Cuts	Sores	Bruises	Tenderness	

FACIAL SERVICE:

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				

Do you use a tanning bed or sunbathe on a regular basis? Yes or No
Do you (**please circle**) burn easily in the sun, blush or turn red? Yes or No
Do you have sensitivity to products? Yes or No
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?

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 Relief's part should I fail to do so. I understand that certain medical issues may contraindicative and may 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: