



Confidential Consultation form

Personal Information

Today's Date: _____

Name: _____ Sex: Male Female
Last First M.I.

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Phone Numbers: _____
Home Work Mobile

E-Mail: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Whom may we thank for referring you? _____

Goals for session

What are your long-term skin care goals? _____

What are your areas of concern? _____

What are your goals for this treatment? _____

Personal Skin Care History

Please check (√) current products you use:

- | | | |
|---|---|--|
| <input type="checkbox"/> Eye make-up remover | <input type="checkbox"/> Skin freshener (Toner, Astringent) | <input type="checkbox"/> Eye cream |
| <input type="checkbox"/> Facial scrub | <input type="checkbox"/> Body lotion/cream | <input type="checkbox"/> Sunscreen # _____ |
| <input type="checkbox"/> Cleansing cream/lotion | <input type="checkbox"/> Day cream | <input type="checkbox"/> Neck cream |
| <input type="checkbox"/> Exfoliants | <input type="checkbox"/> Body scrub | <input type="checkbox"/> Facial soap |
| <input type="checkbox"/> Night cream | <input type="checkbox"/> Mask | <input type="checkbox"/> Body soap |
| <input type="checkbox"/> Hand cream | <input type="checkbox"/> Other: _____ | |

Have you ever had a facial treatment? _____ If yes, where and when? _____

Was it a beneficial experience? _____

Have you ever had a body/bust treatment? _____

How much time do you spend on your daily skin care/make-up routine _____

Do you tend to tan or burn? _____ Do you exercise? How much? _____

Do you smoke? _____ How much sleep do you get per night? _____

How much do you drink of the following:	None	Little	Moderate	Heavy
Water	___	___	___	___
Coffee	___	___	___	___
Tea (green or black)	___	___	___	___
Alcohol	___	___	___	___
Soft Drinks	___	___	___	___

Have there been any activities or products that aggravate your skin? _____



Medical History

Please check (√) where applicable with details.

- | | | |
|--|--|--|
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Distended capillaries | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Plastic surgery |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Artificial implants | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Retin-A™ |
| <input type="checkbox"/> Birth control _____ | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seborrhea |
| <input type="checkbox"/> Blood thinner | <input type="checkbox"/> Hyper/Hypo pigmentation | <input type="checkbox"/> Sensitivities |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hyper/Hypo thyroid | <input type="checkbox"/> Skin Cancer _____ |
| <input type="checkbox"/> claustrophobia | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Contact lens | <input type="checkbox"/> Lupus | <input type="checkbox"/> Underweight/ Overweight |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Metal plates or pins | <input type="checkbox"/> Vitamins _____ |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Nail disorders | <input type="checkbox"/> Other _____ |

Please list medication(s) including vitamins, herbs & topical salves: _____

Do you take or use any products that contain the following (circle all that apply):

- Isotretinoin Tetracycline Retinoic Acid AHA Glycolic Acid Hydroquinone Aspirin Anticoagulent

Have you recently had any type of chemical or glycolic peel? _____

If glycolic, what percentage? _____

If chemical, Please describe: _____

Any recent surgery or dermabrasion? _____ If yes, Please describe: _____

Any allergies? _____ Are you pregnant? _____ Have you tanned in the last 24 hours? _____

Is there anything else I should be aware of before your treatment? _____

Have you recently undergone surgery? (Medical or Cosmetic) _____

Facial Analysis (please check (√) all that apply)

Skin Type

- Normal Dry Combination Oily Sensitive/Breakout Very sensitive/Rosacea Acne Mature

What are your present skin concerns?

- Acne Lesion (cysts) Acne Scars Dilated Capillaries Papules (inflamed) Pustules (inflamed) Black Heads

- Whiteheads Ingrown Hairs Hyperpigmentation (Brown spots from sun, scars, hormonal)

- Eye Area** Crow's Feet/Wrinkles Puffiness Lack of Elasticity Dark Shadows

- Mouth Area** Wrinkles Hyperpigmentation Nasolabial folds

- Check Area** Loss of elasticity Cross wrinkling Sun Damage Dilated pores Uneven Texture Visible Capillaries

- Neck & Décolleté Area** Wrinkles Severe Sun Damage Lack of Elasticity Hyperpigmentation

How often do you receive a facial? Regularly Seldom Never



Consent & Release Form

Facials, Waxing, Dermabrasion & Peels

____I have completed the Confidential Consultation Form accurately. I have been candid in revealing any conditions that could prohibit treatment(s), such as cold sores, pregnancy, use of hormones, recent facial surgery or laser resurfacing, recent use of Retin-A or use of Accutane within the last 18 months.

____I acknowledge that the possibility of an adverse reaction to a waxing, facial, dermabrasion and/or peel can occur and that this is the case regardless of precautions taken. I accept sole responsibility for the treatments I receive and for any medical care that may become necessary. I will immediately contact the Esthetician who performed the treatment of any adverse reactions. In the event that I cannot reach such person, I will immediately seek medical care.

____I fully understand that Serenity Day Spa, LLC and its agents may refuse to perform the treatment(s) I have requested if a contraindication is stated. I understand that I have given up substantial rights by signing this release and that it represents an agreement between Serenity Day Spa, LLC and me. I agree that my participation in treatment(s) is voluntary and I accept the inherent risks.

____I hereby release Serenity Day Spa, LLC, its agents, owners, employees, successors and assigns, and suppliers from any and all damage or injury that may result from the treatment I receive. I represent that all the information provided by me has been true and correct. I am over the age of 17 years old. I hereby authorize the therapist to perform said treatment(s).

Your Esthetician may determine that it is unsafe for you to continue a facial session due to health related concerns. In this event you may be required to provide Serenity Day Spa, LLC with a medical release form from your physician prior to continuing treatment.

I confirm that I have answered all questions pertaining to medical conditions truthfully.

Print Name _____

Signature _____

Date _____



Massage Therapy Analysis

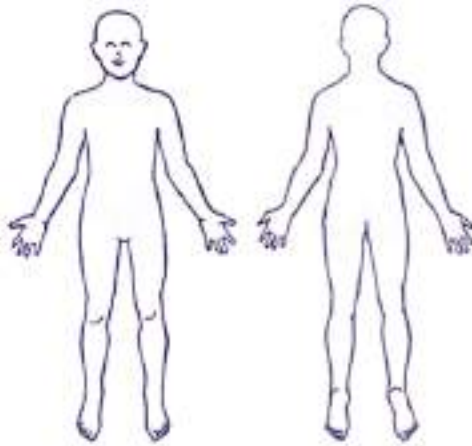
Are you comfortable with having therapeutic massage on the following areas (Please circle):

Gluteal Region	Y/N
Abdomen	Y/N
Pectoral Muscle	Y/N
Feet	Y/N
Face/Head	Y/N

Desired Pressure (please check): Light Firm Deep

What is your desired outcome today? _____

Please indicate with an (X), if any, the area in which you are feel discomfort.





PLEASE READ THE FOLLOWING INFORMATION AND SIGN BELOW
Massage Therapy

I understand that although massage therapy can be therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

It is your responsibility to inform the therapist of any pre-existing conditions, limitations or specific sensitivities and to inform your therapist if you feel any discomfort during the session. If you do experience discomfort, please ask the therapist to adjust the level of pressure or heat.

Our staff has gone through an extensive background check to ensure that your safety is our first priority however any sexual misconduct on the part of the therapist or client will not be tolerated and should be reported to management immediately as appropriate action will be taken.

You understand and voluntarily accept any risks of which you have been advised about associated with your massage, or from any use of the company's facilities, and hereby release Serenity Day Spa, LLC (including its employees, practitioners, agents, and insurers) from all liability for any injury or damage resulting from your failure to inform your therapist of any discomfort during your session.

Your therapist may determine that it is unsafe for you to continue a therapeutic session due to health related concerns. In this event you may be required to provide Serenity Day Spa, LLC with a medical release form from your physician prior to continuing treatment. I confirm that I have answered all questions pertaining to medical conditions truthfully.

Print Name _____

Signature _____

Date _____