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:

___ Eye make-up remover	___ Skin freshener (Toner, Astringent)	___Eye cream
___ Facial scrub	___ Body lotion/cream	___ Sunscreen # _____
___ Cleansing cream/lotion	___ Day cream	___ Neck cream
___ Exfoliants	___ Body scrub	___ Facial soap
___ Night cream	___ Mask	___ Body soap
___Hand cream	___ 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.

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

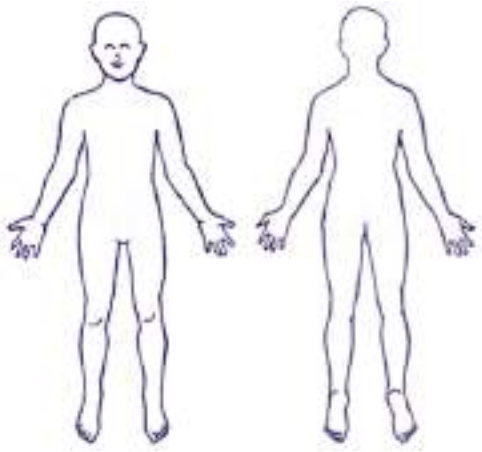
Are you comfortable with having therapeutic massage on the following areas (Please circle):

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 _____