



Please complete this form so that your therapist may tailor your session to best serve your needs.
We want your experience to be relaxing, so please turn cell phones off.

Date _____

Last Name _____ First Name _____

Address _____

City _____ ST _____ Zip _____

Email address for upcoming promotions _____

Telephone _____ Cell Phone _____ Date of Birth _____

Please communicate to your therapist anything you think is relevant, and check off any following conditions or symptoms which apply to you now or in the past.

- | | | |
|--|---|---|
| <input type="checkbox"/> Accident or trauma | <input type="checkbox"/> Allergy to nut oils | <input type="checkbox"/> Asteriosclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Blood Pressure High/Low |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Contact Lens | <input type="checkbox"/> Dentures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hypo or Hyperglycemia |
| <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Muscle Sprain/Strain | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Skin Infections |
| <input type="checkbox"/> Hand/Foot Problems | <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Foot fungus or plantar warts |
| <input type="checkbox"/> History of Cold Sores | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Pregnant? _____ Months |

Allergies _____

Contagious/Infectious Conditions _____

Other Conditions _____

Recent Surgeries _____

Do you have other concerns you therapist should be aware of? _____

Medications (including Retin A/Accutane) _____

Facials ONLY

- | | | | |
|---|--|---------------------------------|--|
| <input type="checkbox"/> Breakouts | <input type="checkbox"/> Blackheads | <input type="checkbox"/> Oily | <input type="checkbox"/> Shiny |
| <input type="checkbox"/> Dry | <input type="checkbox"/> Excessive Redness | <input type="checkbox"/> Rashes | <input type="checkbox"/> Sun Sensitive |
| <input type="checkbox"/> Other skin care issues _____ | | | |

Disclaimer: Healthy Living Spa reserves the right to deny treatment due to medical or other reasons. Treatment(s) do not take the place of physicians' care. Any information exchanged during any services at the Healthy Living Spa is confidential and is only used to provide you with the best services. Technicians will not engage in breast massage of female clients, genital massage is never performed. I understand draping is to be used, covered at all times with only the body part being massaged exposed. I understand that my feedback is an essential element in my treatment, and I have the right to terminate the session at any time, regardless of the reason. I have been provided the information necessary to have made the informed decision to proceed with the treatment(s). I hereby release Healthy Living Spa, its agents, owners, employees, successors and assigns, and suppliers from any and all damage or injury that may result from treatment I receive.

Signature _____ Date _____

Consent to treatment of Minor: I hereby authorize services to be administered to my child or dependent. As per Texas law any persons under age 17 must be accompanied by parent or guardian and authorize informed consent to minor.

Signature of Parent or Guardian _____ Date _____