Lilia
the spa at lilia

Date:_____

Personal Health Information

Therapist Gender Preference ☐ Male ☐ Female ☐ No Preference
Would you like to be educated about your therapy during your service? ☐ Yes ☐ No
*If you would prefer total relaxation, your therapist may speak with you after your service any thoughts they have to help you live life better.

Name:_____

Address:_____City, State, Zip:_____

Phone (H)_____ Phone (C)_____ Phone (W)_____

Email:_____

DOB: / / Age: _____

Occupation:_____ City/State:_____ Phone:_____

Primary Physician:_____ City/State:_____ Phone:_____

Emergency Contact: _____ Relationship:_____ Phone:_____

Previous History

Please list any prior Surgeries/Accidents _____
Are you currently under a physician's care? ☐ Yes ☐ No If yes, please explain_____
List current medications, including aspirin, ibuprofen, etc. _____
Are you recently post-operative? ☐ Yes ☐ No If yes, please explain_____
List stress reduction and exercise activities _____Frequency_____
Are you pregnant? Or trying to become pregnant? ☐ Yes ☐ No Are you taking birth control or HRT? ☐ Yes ☐ No

Musculo-Skeletal

- ☐ Tendonitis
- ☐ Broker/Fractured Bones
- ☐ Sprains/Strains
- ☐ Neck, shoulder, or arm pain
- ☐ Jaw pain/TMJ
- ☐ Lupus
- ☐ Bone or joint disease
- ☐ Bursitis
- ☐ Arthritis
- ☐ Lower Back, hip or leg pain
- ☐ Migraines/Head injuries
- ☐ Spasms/Cramps

Circulatory

- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Lymph edema
- ☐ Sinus Problems
- ☐ Hepatitis C
- ☐ Diuretics
- ☐ Varicose Veins
- ☐ Low Blood Pressure
- ☐ Breathing Difficulty
- ☐ Allergies
- ☐ Blood thinners
- ☐ High Cholesterol
- ☐ Hemophilia

Skin

- ☐ Athletes Foot
- ☐ Warts
- ☐ Allergies _____
- ☐ Rashes
- ☐ Eczema/Psoriasis
- ☐ Hives

Nervous System

- ☐ Herpes/Shingles
- ☐ Chronic Pain
- ☐ Sleep Disorders
- ☐ Other _____
- ☐ Numbness/Tingling
- ☐ Fatigue

Other

- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Tuberculosis'
- ☐ Weight loss med's _____
- ☐ Asthma
- ☐ Thyroid Condition
- ☐ Laxatives

Infectious Diseases

- ☐ Contagious Skin Disorder
- ☐ HIV/AIDS
- ☐ Disease Name(s) _____

Massage Health Information

Have your ever received a professional massage? ☐ Yes ☐ No If yes, frequency_____ Date of last Massage? _____
If yes, what did you like most?_____ What did you dislike?_____
What results do you want from your massage?_____

Please check the areas of your body that you give permission to receive massage.
☐ Back ☐ Legs ☐ Buttocks ☐ Arms ☐ Abdomen ☐ Chest ☐ Neck ☐ Head ☐ Face ☐ Feet

Are you currently seeing a medical practitioner? ☐ Yes ☐ No If yes, please explain_____
Are you currently experiencing any pain in your joints or muscles? ☐ Yes ☐ No If yes, please explain _____
How long have you been experiencing this pain?_____
What makes it worse or better?_____

Do you need therapeutic work or do you only want relaxation? ☐ Therapeutic ☐ Relaxation

Skin Health Information

Describe your skin (Check all that apply)

_ Normal	_ T-Zone Combination	_ Wrinkled	_ Uneven/Blotchy	_ Rosacea	_ Cystic
_ Oily	_ Freckles	_ Saggy	_ Mature	_ Hypo-Pigmented	_ Breakouts How often?
_ Dry	_ Sun Damaged	_ Firm	_ Keloid Scars	_ Hyper-Pigmented	_____
_ Florid	_ Large Pores	_ Acne	_ Small Pores	_ Black Heads	_ Scarred

How many servings of dairy do you consume daily? _____ Glasses of water? _____ Do you eat junk food? ☐ Yes ☐ No

I consume: Coffee_____Amt. per day Tea_____Amt. per day Soda_____Amt. per day Alcohol_____Amt. per day Smoke/Tobacco_____Amt. per day

Are you allergic to: ☐ Milk ☐ Apples ☐ Grapes ☐ Shell fish ☐ Aloe Vera ☐ Aspirin

Does your skin ever appear shiny a few hours after cleansing? ☐ Yes ☐ No

Does your skin ever feel tight, dry or flaky? ☐ Yes ☐ No

Do you consider your skin: ☐ Sensitive ☐ Resilient

Eye Color: ☐ Blue ☐ Green ☐ Hazel ☐ Grey ☐ Light Brown ☐ Medium Brown ☐ Dark Brown ☐ Black

Skin Tone: ☐ Pale ☐ Light ☐ Reddish/Freckles ☐ Light Olive ☐ Medium Olive ☐ Dark Olive ☐ Brown ☐ Black

What is your ethnic heritage? _____

Are you using any of the following: ☐ Accutane ☐ Zovirax ☐ Tetracycline ☐ Differen ☐ Retinol ☐ Retin A ☐ Renova ☐ Glycolic ☐ AHA ☐ Benzoyl peroxide ☐ Salicylic acid

Have you ever used products that cause a bad reaction? ☐ Yes ☐ No Please describe_____

Do you have telangiectasia/broken surface capillaries? ☐ Yes ☐ No If yes, what areas? _____

Do you: ☐ Burn ☐ Usually burn ☐ Burn then tan ☐ Usually tan ☐ Always tan

Have you ever used a tanning bed? ☐ Yes ☐ No If yes, how often? _____

Do you get cold sores/fever blisters? ☐ Yes ☐ No Do you take prescription meds to treat them? _____

Do you get facial waxing, electrolysis, dermabrasion, microderm, LHR, IPL or use depilatories? ☐ Yes ☐ No

Have you had collagen injections, Botox, Restylane, or Radiesse recently? ☐ Yes ☐ No

Have you ever had a peel before? ☐ Yes ☐ No What kind? ☐ Lactic ☐ TCA ☐ Jessner ☐ Phenol ☐ Herbal ☐ Glycolic

I use these products on my skin: (Check all that apply) ☐ Scrub ☐ Eye cream ☐ Toner ☐ Sunscreen ☐ Spf? _____ ☐ Cleanser ☐ Astringent ☐ Day moisturizer ☐ Night moisturizer ☐ Mask ☐ Bar soap ☐ Special product ☐ Makeup

What about your skin bother you?_____

How can I help you today?_____

Notes:

_____

_____

_____

_____

It is my choice to receive treatments from Lilia Day Spa. I realize that the treatments are being given for the well-being of my body, skin and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised. I understand that my practitioner(s) do not diagnose illness. Disease, or any physical or mental disorder, nor do they prescribe medical treatment, drugs or perform spinal thrust manipulations. I acknowledge that skin, massage, or nail therapy is not a substitute for medical examination or diagnosis, and that is recommended that I see a primary health car provider for that service. I have stated al medical conditions that I am aware of and will update the practitioner(s) of any changes in my health status.

Signature:_____Date:_____

Parent/Guardian Signature (if 18 years or younger):_____Date:_____