Lilia Day Spa

Date:

Personal Health Information

(Please Print)

Therapists 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:____________________ ❑ **Mr.** ❑ **Mrs.** ❑ **Miss** ❑ **Ms.**

Address:____________________City, State, Zip:____________________

Phone (H)__________ Phone (C)__________ Phone (W)__________

Email:____________________

DOB: / / Age: ________ Sex: ❑ Male ❑ Female

Occupation:__________ City/State:__________ Phone:__________

Primary Physician:__________ City:__________ Phone:__________

Emergency Contact: __________Relationship:__________Phone:__________

Referred by:____________________

Previous History (include year and treatment received)

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__________

Musculo-Skeletal		**Circulatory**	
☐ Bone or joint disease		☐ Heart Condition	
☐ Tendonitis	☐ Bursitis	☐ Varicose Veins	
☐ Broker/Fractured Bones	☐ Arthritis	☐ High Blood Pressure	
☐ Sprains/Strains	☐ Spasms/Cramps	☐ Low Blood Pressure	
☐ Lower Back, hip or leg pain		☐ Lymph edema	
☐ Neck, shoulder, or arm pain		☐ Breathing Difficulty	
☐ Migraine Headaches/Head injuries		☐ Sinus Problems	
☐ Jaw pain/TMJ	☐ Lupus	☐ Allergies	☐ Other
Skin		**Nervous System**	
☐ Allergies		☐ Herpes/Shingles	
☐ Rashes		☐ Numbness/Tingling	

☐ Athletes Foot	☐ Chronic Pain
☐ Warts	☐ Fatigue
☐ Eczema/Psoriasis	☐ Sleep Disorders
☐ Other	☐ Other
Infectious Disease	**Reproductive**
☐ Disease Name(s)	☐ Pregnant? Stage______________________
☐ Contagious Skin Disorder	☐ PMS
☐ HIV/AIDS	☐ Other
Digestive	**Other**
☐ Constipation	☐ Cancer/Tumors
☐ Gas/Bloating	☐ Diabetes ☐ Varicose Veins
☐ Diverticulitis	☐ Eating Disorders ☐ Depression
☐ Irritable Bowl Syndrome	☐ Thyroid Condition ☐ Asthma
☐ Other	☐ Drug/Alcohol /Nicotine/Caffeine Addiction

Skin Health Information

Describe your skin (Check all that apply)

☐ Normal ☐ Oily ☐ Dry ☐ T-Zone Combination ☐ Freckles ☐ Sun Damaged ☐ Uneven/Blotchy ☐ Mature
☐ Wrinkled ☐ Saggy ☐ Firm ☐ Large Pores ☐ Small Pores ☐ Post-Inflammatory ☐ Milia
☐ Cystic ☐ Occasional Breakouts ☐ Scarred ☐ Black Heads ☐ Melasma ☐ Florid ☐ Rosacea
☐ Sallow ☐ Asphyxiated ☐ Perfume-Stained ☐ Hypo-Pigmented ☐ Acne ☐ Hyper-Pigmented

Do you consider your skin: ☐ Sensitive ☐ Resilient Are you using Accutane? ☐ Yes ☐ No

Are you using Retinol A? ☐ Yes ☐ No How Frequently?______________________ Where do you apply it?________________

Are you using Hormones/other medications? ☐ Yes ☐ No If yes, which one(s)?________________
____

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Do you have telangiectasia/broken surface capillaries? ☐ Yes ☐ No

Do you currently have sunburn/windburn? ☐ Yes ☐ No

Do you get cold sores/fever blisters? ☐ Yes ☐ No

Are you using Gylcolic/AHA home care products that caused a bad reaction? ☐ Yes ☐ No If yes, which ones?________________

How does your skin react to them?

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

Eye Color: ☐ Blue ☐ Green ☐ Hazel ☐ Grey ☐ Lt.Brown ☐ Med.Brown ☐ Dk. Brown ☐ Black

Skin Tone: ☐ Pale/White ☐ Light ☐ Reddish/Freckles ☐ Lt .Olive ☐ Med. Olive ☐ Dk. Olive ☐ Brown ☐ Black

What is your ethnic heritage? ____

Do you go to tanning booths? ☐ Yes ☐ No

Do you get facial waxing/electrolysis/or use depilatories? ☐ Yes ☐ No If yes, please wait 5 days between treatments.

Have you had collagen injections recently? ☐ Yes ☐ No If yes, please wait 7 days between treatments.

Have you ever had a peel before? ☐ Yes ☐ No If yes, within the last 14 days ☐ Yes ☐ No What kind?_____________

Describe your reaction:____

Describe your home skin care regime:____

What about your skin bother you?____

What about your skin would you like to have corrected?____

Massage Health Information

(please alert your therapist if you are pregnant)

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?____

Prioritize the areas of your body you would prefer to be massaged?

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

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.

I release the therapist(s) and the staff harmless from any liability that may result from this treatment.

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Signature:____Date:________

Parent/Guardian Signature (if 18 years or younger):________________________________ Date:_________

Please hold on to your paperwork and your therapists will be with you shortly.