

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

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

Skin

- Allergies
- Rashes

Circulatory

- Heart Condition
- Varicose Veins
- High Blood Pressure
- Low Blood Pressure
- Lymph edema
- Breathing Difficulty
- Sinus Problems
- Allergies Other

Nervous System

- Herpes/Shingles
- 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)? _____

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 Glycolic/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 you 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 care provider for that service. I have stated all 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.

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.