DAY SPA AND SALON

PERDIDO KEY, FLORIDA

MM30452

Name: ______________________________ Date: ______________

Date of Birth: ______________ Email: ______________________________

Home Phone #: ____________________ Mobile Phone #: ____________________

Address: ____

City: ____________________ State: ______________ Zip: ______________

Occupation: ____

Emergency Contact: ________________________ Phone #: ______________

Local Resident? ________

Owner of Eden Unit? ________ Guest of Eden Unit? ________

If so, what unit #? ________ If so, what unit #? ________

Owner of other Condo Property? ______________

If so, at what condominiums? ______________

Guest of other Condo Property? ______________

If so, at what condominium? ______________

How often do you usually visit? ____

____

How did you hear about us? ____

Do you often use Facebook, Twitter, or other media network for business/ promotional offers? If so, which ones? ____

Would you like us to send promotional offers/special pricing to the email you listed above? ________

How would you like for us to remind you of your upcoming appointments?

Phone Call? ________ Text Message? ________ Email? ________

Signature: ______________________________ Date: ______________

Emerald Oasis

Health Information for Spa Services: *Client Name:* ______________________

Are you currently under a physician's care? _______ If so, for what condition(s)? ___________________
____
____

Are you currently taking any medications? _______ If so, please list. ____________________________
____
____

Do you have any allergies to cosmetics, food, or medications? ________ If so, please list. ___________
____
____

Do you sunbathe? Yes ____ No ____ Have you ever used Accutane? Yes ____ No ____
Do you wear contacts? Yes ____ No ____ Have you ever used AHA/Glycolic? Yes ____ No ____
Have you ever used Retin A? Yes ____ No ____ Your Stress level is: Low ____ Medium ____ High ____

Please check any health challenges that may pertain to you:

___Acne
___Arthritis
___Asthma
___Back Problems
___Blood Clots
___Bruises
___Cancer
___Claustrophobia
___Constipation
___Diabetes
___Diverticulitis
___Epilepsy
___Fever Blisters
___Fibromyalgia
___Fractures
___Headaches
___Heart Disease
___Hemophilia
___AIDS/HIV+
___Hepatitis
___High Blood Pressure
___Insomnia
___Metal Bones/Pins/Plates
___Osteoporosis
___Pacemaker
___Phlebitis
___PMS
___Pregnancy
___Psychological
___Severe Lacerations
___Scoliosis
___Sinus Problems
___Skin Diseases
___Surgeries
___Tendonitis
___Varicose Veins
___Whiplash

Please list any other medical conditions or problems you may be experiencing: ____________________
____

Any pain or tension? ______ Location of pain: ____
____

Our fully licensed staff is here to see that you have a relaxing and enjoyable time at the spa. Our only wish is for you to enjoy your experience to the fullest. However, should a situation arise that makes the service provider uncomfortable, they reserve the right to refuse and/or terminate any and all services immediately. The client will be responsible for payment in full. There is a 24 hour cancellation policy and we will charge for missed appointments.

I understand that massage therapy and/or skin care treatments are for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation, skin care maintenance, and improvement of circulation and energy flow. I understand that massage therapy and/or skin care treatments are not a substitute for a medical exam or diagnosis by a physician. I have stated all my known medical conditions and agree to keep my massage therapist, esthetician, and/or cosmetologist informed of any changes in my health prior to each session.

Signature: ____ Date: ______________________