

# SPA BOTANICA

# CLIENT PROFILE

Name: \_\_\_\_\_ Birthday:     /     /

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Preferred Phone: (     )     -      Home  Cell

What do you hope to accomplish through your visit today? \_\_\_\_\_

## Communication Preferences

I would like to receive appointment reminders by:  Phone  Email Address \_\_\_\_\_

If receiving appointment reminders by phone but you would like to receive Spa Botanica's monthly specials via email please list address above.

May we send birthday cards, thank you notes & spa-related information to your mailing address?  Yes  No, please exclude me from your mailing

## Who may we thank for referring you to our spa?

Existing Customer \_\_\_\_\_  Spa/Hotel Staff \_\_\_\_\_  Hotel Literature/Signage

Hotel Website  Internet  Mail  Newspaper  Radio  Yellow Pages  Pinnacle Country Club  Facebook  Twitter  Gift Card

## GENERAL HEALTH HISTORY

Please indicate below any condition you currently have or have experienced in the past:

- |   |   |   |  |   |   |
|---|---|---|--|---|---|
| <input type="checkbox"/> Accident/Surgery | <input type="checkbox"/> Broken Bones         | <input type="checkbox"/> Contact Lenses   | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Metal Plates       | <input type="checkbox"/> Scoliosis      |
| <input type="checkbox"/> Acne             | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Depression       | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Seborrhea      |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Claustrophobia       | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Muscle Sprain      | <input type="checkbox"/> Seizures       |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Eczema           | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Neck/Shoulder Pain | <input type="checkbox"/> Shoulder Pain  |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Contact Dermatitis   | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Currently Lactating | <input type="checkbox"/> Numbness/Tingling  | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Back Pain        | <input type="checkbox"/> Currently Pregnant   | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Lower Back Pain     | <input type="checkbox"/> Psoriasis          | <input type="checkbox"/> Sleeplessness  |
| <input type="checkbox"/> Blood Pressure   | <input type="checkbox"/> Hearing Aid          | <input type="checkbox"/> Menopause        | <input type="checkbox"/> Rosacea             | <input type="checkbox"/> Thyroid            | <input type="checkbox"/> TMJ (jaw)      |

Please provide specific details for health conditions checked. Please also list medications you are currently taking:

Have you taken medication (including Tylenol) for fever and/or had symptoms of contagious illness such as cold or flu in the last 48 hours?

Yes  No *For the protection of your health, our staff and guests, please answer honestly. Some spa treatments may worsen your symptoms.*

## CONSENT FOR TREATMENT AND CODE OF CONDUCT

I understand massage, skin and body treatments are for relaxation, stress reduction, muscle pain relief, beautification and for increasing circulation. I understand spa treatments are not a substitute for medical treatment or diagnosis. I have stated all my known medical conditions honestly. I understand Spa Botanica reserves the right to refuse treatment if determined unsafe for me due to any current or past medical conditions. \_\_\_\_\_ (initial)

As a spa guest, I agree to communicate my preferences, expectations, concerns and discomforts to my therapist throughout my visit. I will treat guests and staff with the same courtesy and respect I will receive- by making prior arrangements for children, arriving on time for appointments, turning my cell phone off before entering the spa, speaking quietly in "whisper zones" and adhering to all other published policies and procedures. I understand any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment for the "full" scheduled appointment. Should a therapist make me uncomfortable, I too have the right to end service at any time and will promptly report misconduct to the spa director. \_\_\_\_\_ (initial)

Should I need to cancel or change future appointment dates and/or times, I agree to give a full 24 hour notice for single appointments and 48 hours for multiple appointments. If I choose to cancel services with less than the required time, I am responsible for payment of services scheduled. I understand charges will be applied to the credit card and/or gift card/s used to confirm my initial reservation. \_\_\_\_\_ (initial)

Client Signature \_\_\_\_\_

Date     /     /

**PLEASE COMPLETE THIS SECTION IF YOU ARE RECEIVING A MASSAGE OR BODY TREATMENT**

What are your present concerns?

- Dry Skin  Breakouts  Elasticity/Firmness  Cellulite
- Muscle Tension/Pain Mgmt

How often do you receive massage?

- Weekly  Monthly  Rarely  This is my first massage

How often do you receive body treatments?

- Monthly  Quarterly  Rarely  This is my first body treatment

What type of massage pressure do you prefer?  Light  Medium  Firm

Please list areas you would like us to spend extra time on today:

\_\_\_\_\_

Do you use any of the following products?

- Body Scrub                      What Brand? \_\_\_\_\_
- Body Wash/Soap                What Brand? \_\_\_\_\_
- Body Moisturizer                What Brand? \_\_\_\_\_
- Body Firming Cream            What Brand? \_\_\_\_\_
- Bath Oil                            What Brand? \_\_\_\_\_
- Hot/Cold Packs
- Aromatherapy                    What Brand? \_\_\_\_\_

Please list any areas you do not want massaged today:

\_\_\_\_\_

**PLEASE COMPLETE THIS SECTION IF YOU ARE RECEIVING A FACIAL OR FACIAL MASSAGE**

**SKIN TYPE**

- Normal  Oily  Dry  Combination  Sensitive Skin

When exposed to the sun, my skin:

- Burns easily  Tans easily  Never Burns  Never Tans

**EYES**

- Crows Feet/Wrinkles  Puffiness  Lack of Elasticity  Dark Shadows

**MOUTH**

- Wrinkles  Nasolabial Fold  Hyper Pigmentation

**CHEEKS**

- Loss of Elasticity  Cross wrinkles (sun damage)  Dilated Pores
- Hyper pigmentation  Uneven Texture  Visible Capillaries

**NECK & Décolleté AREA**

- Wrinkles  Lack of Elasticity  Sun Damage  Hyper pigmentation

How often to you receive a facial?  Regularly  Seldom  Never

If you could change one thing about your skin, what would it be?

\_\_\_\_\_

Have you ever had an allergic reaction to a skincare product?  Yes  No  
If yes, please explain. \_\_\_\_\_

**CURRENT SKIN CONCERNS**

- Acne  Aging  Blackheads  Dry Skin  Enlarged Pores
- Sensitive/Breakout  Very Sensitive/Rosacea  Acne  Mature
- Hyper pigmentation  Oily Skin  Redness  Scars  Tightness

**FACIAL PROCEDURES**

Please check all services you have recently received:

- Microdermabrasion
- Chemical Peel
- Waxing
- Botox Injections
- Laser Treatments
- Collagen Injections

Please list the brand of product you use for the following:

- Eye makeup remover \_\_\_\_\_
- Cleanser \_\_\_\_\_
- Toner \_\_\_\_\_
- Moisturizer \_\_\_\_\_
- Exfoliator \_\_\_\_\_
- Mask \_\_\_\_\_
- Make-up \_\_\_\_\_
- Sunscreen \_\_\_\_\_