

| | | |
|--------------------------------|-------------|-----------------|
| Name: | Date: | Phone: |
| Address: | Occupation: | Phone Provider: |
| City: | State: | Zip Code: |
| Emergency Contact Name/Number: | | Date of Birth: |
| How did you hear about us? | | Email: |
| | | Referral Name: |

Preferred Method of Contact (please select all that apply): Text Message Email Phone All

GENERAL HEALTH

Rate Your Stress Level: (5 = Highest, 1 = Lowest) **1 2 3 4 5**

List any allergies including food product:

Check if you: Smoke Drink Alcohol Consume Caffeine If any, how often?

List any accidents or surgeries within the past 2 years:

Do you have any metal implants, a pacemaker or body piercings?

Do you wear contact lenses? Yes No

Are you now under a Doctor's Care?

List any medications you are taking (use back of form if necessary):

HEALTH HISTORY

Heart Condition Lymphedema Herpes/Shingles High Blood Pressure Low Blood Pressure

Numbness/Tingling Sinus Problems Allergies Chronic Pain Varicose Veins

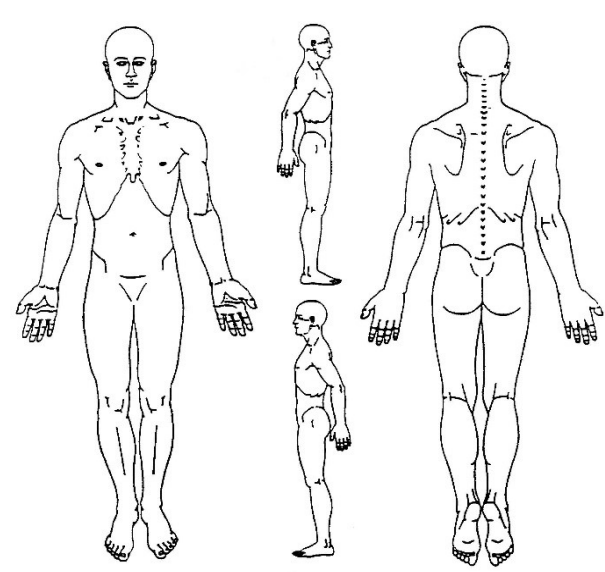
Rashes Jaw Pain/TMJ Blood Clots Constipation Sprains/Strains Asthma

Diabetes Headaches Arthritis Spasms/Cramps Broken/Fractured Bones

Pregnancy (___ weeks) Fatigue/Sleep Disorder Depression/Anxiety Cancer - Currently? Y / N

Other (explain):

MASSAGE THERAPY (Do not fill out if you are visiting for Skin Care services)

| | | |
|--|--|--------|
|  | Use body chart to circle any areas of pain or discomfort. | |
| | Rate Your Pain: No Pain 0 1 2 3 4 5 Severe | |
| | How do these symptoms effect your life? | |
| | Have you had a professional massage before? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | If so, when was your last massage: | |
| | Do you bruise easily? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | GOAL FOR MASSAGE SESSION | |
| | Pain Relief/Injury Rehabilitation | Other: |
| | Relaxation | |
| | Stress Reduction | |

Company Use Only:
 Reviewed Added into system

| |
|--|
| SKIN CARE (Do not fill out if you are visiting for Massage Therapy services) |
| Do you use: <input type="checkbox"/> Accutane <input type="checkbox"/> Retin A <input type="checkbox"/> Renova <input type="checkbox"/> Adapalene <input type="checkbox"/> Other Prescription Products <input type="checkbox"/> None |
| Have you recently had: <input type="checkbox"/> Chemical Peels <input type="checkbox"/> Microdermabrasion <input type="checkbox"/> Laser Services <input type="checkbox"/> Botox/Fillers <input type="checkbox"/> Waxing/Suguring <input type="checkbox"/> None |
| Products you use: <input type="checkbox"/> Soap <input type="checkbox"/> Cleanser <input type="checkbox"/> Exfoliant <input type="checkbox"/> Masque <input type="checkbox"/> Serum <input type="checkbox"/> Toner <input type="checkbox"/> Moisturizer - Brand? |
| Are you currently using any skin care products that contain acid (Glycolic, Lactic, Hydroxy, Vit A, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Skin Type: <input type="checkbox"/> Oily/Congested <input type="checkbox"/> Dry/Dehydrated <input type="checkbox"/> Sensitive/Redness <input type="checkbox"/> Combination <input type="checkbox"/> Normal <input type="checkbox"/> Other: |
| Have you been tanning in the last 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any skin sensitivity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: |
| FITZPATRICK SELF ASSESSMENT (Do not fill out if you are visiting for Massage Therapy services) |
| Please select the box that applies to you: |
| <input type="checkbox"/> I never tan, always burn <input type="checkbox"/> I tan with difficulty, usually burn <input type="checkbox"/> Average tanning, sometimes burn |
| <input type="checkbox"/> Easily tan, rarely burn <input type="checkbox"/> I never burn |

For General Liability (please sign):

By signing this Release of Liability and Waiver, I am confirming that I recognize that there may be inherent risks associated with using certain equipment, participating in programs and/or receiving spa treatments. I acknowledge and agree that I am responsible for my own health; that the spa associates and/or technicians are not health care practitioners and cannot be expected to diagnose and/or treat individual health problems. I understand that I am responsible for discussing any questions that I may have concerning my health conditions (if any) throughout any program or treatment at the spa and, should health-related symptoms occur, I will cease my participation and inform spa personnel of the symptoms. In the event that I have reason to believe that medical clearance must be obtained prior to participation in any spa treatments, therapies, or facility equipment, I agree to first consult a physician and obtain written permission from a physician prior to the commencement of any program, treatment or activity. By voluntarily choosing to receive spa-related treatments and/or participate in spa-related activities and programs, I warrant that to the best of my knowledge, I have no disability, impairment or ailment that prevents me from receiving such treatments and/or engaging in such participation.

Consequently, in light of the foregoing, I hereby release The Workshop (and its parent corporation(s), subsidiaries, affiliated corporations, and their respective officers, directors, shareholders and employees) and waive any and all claims, liabilities, or damages for personal injuries that I may experience directly or indirectly from receiving spa related treatments, utilizing the facilities and/or participating in the programs or activities offered by The Workshop.

Initial _____

I also understand that The Workshop requires 24 hours notice of cancellation. If the cancellation is within 24 hours of the appointment, full charges will apply and any vouchers or gift certificates being used for that session will be redeemed.

Initial _____

Sign: _____ Date: _____

Company Use Only:
 Reviewed Added into system

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 Reviewed Added into system

[Empty form area for intake information]

Company Use Only:
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