Kneaded Relief Day Spa
Client General Information Form

Name (*First, M.I., Last*)________________________________ Address____________________________
City______________________________________ State__________ Zip______________________
Age____ Birth Date__________ Sex: M F Height_____ Weight_____ Robe size______ Shoe size________
Email (please print clearly) ____

I would like to receive email specials: Yes ☐ No ☐

I would like to receive a monthly e-newsletter: Yes ☐ No ☐

Telephone (home) ___________________ (cell) ___________________ (work) ____________________
How would you prefer appointment confirmations? Phone ☐ (Primary phone: H C W) Email ☐
Occupation _____________________________
Primary Physician_____________________________ Physician's Phone ______________________
Referred by ______________________________ Phone (if known) _________________________
Emergency Contact ______________________________ Phone _____________________________

Client Health History:

Please check any of the following conditions that may pertain to you.
The information you give will help us determine the most safe and effective treatment for you.

Do You Have Any Health Issues?

☐ Blood Disorders
  ☐ Phlebitis/Blood Clot Disorder
  ☐ Anemia
☐ Heart Problems/Disease
☐ High Blood Pressure (Medication:___________)
☐ Low Blood Pressure (Medication:___________)
☐ Poor Circulation/Cold Hands/Feet (Circle one)
☐ Numbness/Tingling/Twitches (Circle one)
  Where?:____________________
☐ Thyroid (Circle one: Over or Under Functioning)
☐ Varicose Veins -Diagnosed by Dr? ☐ Yes ☐ No
☐ Psoriasis
☐ Fibromyalgia
☐ Arthritis/Rheumatism - Type: ____________
☐ Cancer - Current or Remission?
  Type: _______________
☐ HIV/AIDS
☐ Hepatitis – Type: ____________
☐ Diabetes – Onset: ________
Headaches - Type/Frequency: _____________

What is your level of stress?
☐ Modest ☐ Average ☐ Severe

Do you have any implants? ☐ Yes ☐ No
*Pacemaker, Pins in Bones, Etc.*_________________

Do you wear: Contact Lenses? ☐ Yes ☐ No
Hearing aids? ☐ Yes ☐ No
Dentures? ☐ Yes ☐ No

Have you undergone treatment from a dermatologist? *If so, for what conditions?*________
____

Please list all allergies/sensitivities you have to any product or ingredient (Oils, Nuts, Iodine, etc.):
____
____

Recent Injuries:
Type and Date:____________________________
____

Recent Surgeries:
Type and Date:____________________________
____

Current Symptoms:__________________________
____
____

Do you use tanning beds/sunbathe? ☐ Yes ☐ No
*If Yes, How Often?*________________________

Are you pregnant? ☐ No ☐ Yes - Due date: ______

Are you taking birth control pills? ☐ Yes ☐ No
Accutane? ☐ Yes ☐ No
Retin A? ☐ Yes ☐ No

Other current medications (including topical):
Name:_____________________________________
____

For what condition(s):______________________
____

Any contagious diseases (Please List)___________
____
____

Is there anything else we should know about your well-being?_________________________________
____

Kneaded Relief Day Spa
Appointment Contract

Our cancellation policy is as follows:

1. If you must cancel, we ask for 24 hour notification (Monday-Thursday) or 48 hours (Friday-Sunday or with Packages), so that we may offer that appointment to someone on our waiting list.
2. In the event of a cancellation less than the notification time stated above, there will be a charge for 50% of the treatment cost.
3. In the event of a missed appointment ("no show"), there will be a charge for 100% of the treatment cost.

We do understand that emergencies arise and weather conditions may become hazardous. Please call us so that we are aware of your situation.

<u>Kneaded Relief would like to ensure you that your spa day is exactly what you request.</u>

- Please be aware that a consultation with your therapist will be a part of your service and is included within the service time.
- I understand that the various treatments given here are for the purpose of relaxation, stress reduction, relief from muscular tension or spasm, reduction of scar tissue and chronic pain, and for the promotion of circulation, lymph activity, flexibility, and energy flow.
- The therapist must be made aware of any existing physical and mental condition; hence I have stated all my known medical conditions. I take it upon myself to keep them updated on my physical and mental health, conditions and concerns, and understand that there shall be no liability on the therapist's part should I fail to do so.
- I understand that communication is an essential part of my treatment and agree to tell my therapist if I am uncomfortable, want less pressure or need more.
- I also understand that any sexual suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment in full.

By signing below I am agreeing to these terms.

Signature: ____ Date: __________

If you are delighted with your service today, reward yourself by booking your next service and save!
Ask for details at Guest Services.

Kneaded Relief Day Spa
Client Massage Form

Name______________________________________

Have you had a professional massage before? Yes ☐ No ☐

Do you have any difficulty lying on your ☐ front, ☐ back or ☐ side?

If yes, please explain: ______________________________________

Do you sit for long hours at a workstation, computer, or driving? Yes ☐ No ☐

Do you perform any repetitive movement in your work, sports, or hobby? Yes ☐ No ☐

Do you see a chiropractor? Yes ☐ No ☐ If yes, how often? ________________

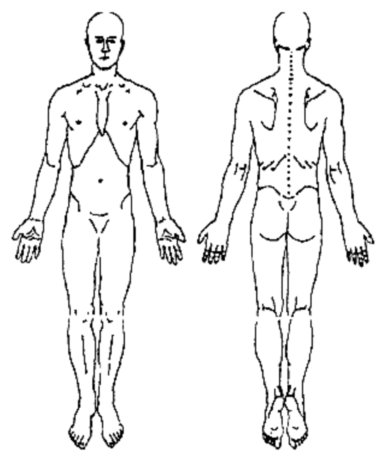
Please identify any tight, tense, or sore areas or areas of chronic muscular pain that you would like the therapist to address. You may also mark them on the figures below:

Muscles/Joints

Circle one: Pain/Stiffness/Spasms

	Current	Previous
Neck	______	______
Low Back	______	______
Mid Back	______	______
Upper Back	______	______
Shoulders	______	______
Left/Right Leg	______	______
Left/Right Knee	______	______

Please explain ___________________
____



Please *check* any of the following conditions that may pertain to you.
The information you give will help us determine the most safe and effective treatment for you.

( ) Insomnia
( ) Chronic Fatigue
( ) Depression/Anxiety
( ) Difficult Digestion/Constipation
( ) Bruise Easily
( ) Skin Conditions:
Type:__________________

( ) Earaches
( ) Jaw Pain/TMJ
( ) Osteoporosis
( ) Sciatica
( ) Paralysis
( ) Seizures
( ) Parkinson's Disease

( ) Menstrual Problems/PMS
( ) Menopausal Problems?
( ) Breast Tenderness

( ) Smoker ___Past ___Present
( ) Sinus
( ) Chronic Cough
( ) Frequent Colds
( ) Shortness of Breath/Asthma
( ) Other Breathing Problems
Type:_________________

( ) Spinal Problems
Type:_____________
( ) Multiple Sclerosis

( ) Foot Problems
___Athletes Foot
___Warts
___Bunions
( ) Prosthesis
___Pins
___Limbs

If necessary, please explain any condition that you have marked above:__________________________
____
____

Kneaded Relief Day Spa

Client Treatment Form

Facials/Body Treatments/ Waxing /Nail Services

Name______________________________________

Please fill out all checked sections below:

☐ Facial/Body Treatment

Diet -- Check All That Apply
☐ I take Nutritional Supplements ______________________________
☐ I take vitamin supplements daily (Please List)__________________ ______________________________
☐ I eat "junk food" often
☐ I smoke

	Yes	No
Are You Using Alpha-Hydroxy Acids/Fruit Acids?		
Have You Ever Had An Adverse Reaction To A Cosmetic Product?		
*If so, which product or ingredient?*______________________________ ______________________________ ______________________________		

☐ Facial

Is Your Skin Sensitive? ☐ Yes ☐ No

What Are You Currently Using for Your at Home Facial Care? ______________________________

____

____

____

Do You Have Any Diagnosed Skin Conditions?

*If so, describe?*______________________________

____

What Medications Are You Using to Treat the condition(s)? ______________________________

____

☐ Body Treatment

What Results Would You Like to See From Your Service?______________________________

____

____

Do You Suffer From:

☐ Back Problems ☐ Dry, Flaky Scalp

☐ Dry Skin ☐ Dry, Damaged Hair

☐ Cellulite

What Products Do You Currently Use?

☐ Soaps ☐ Shower/Bath Gel

☐ Body Scrub ☐ Body Lotion/Crème

☐ Sun Protection ☐ Self-Tanner

☐ Other______________________________

Which Body Areas Are Of Concern To You?_______

____

Why?______________________________

____

☐ Waxing

Is this your first hair removal treatment? ☐ Yes ☐ No

If no, have you ever experience bruising due to a treatment? ☐ Yes ☐ No

Have you undergone microdermabrasion in the past month? ☐ Yes ☐ No

Please indicate below the date of your most recent: Chemical Peel ___________ Waxing ________________

Please indicate whether you have any of the following conditions or if you are taking any of the following medications: _____ Cortisone _____ Tetracycline _____ Renova/Differin (in the last month)

_____ Dermal Abrasions _____ Warts/Herpes _____ Eczema _____ Rosacea

☐ Nail Service

Have you ever worn artificial nails?__________

If yes, which type? Acrylic, Silk Wraps, Gel Caps, Fiberglass, Other______________________________

Did you ever experience a problem with these?______________________________

If yes, explain:______________________________

Do you currently have problems with your nails/skin? (Weak, Brittle, Fungus, etc)

Please explain:______________________________

What improvements would you like to see with regard to your nails and hands/feet?______________________

____