del soul
SPA

Personal Information

Full Name: _____ Date of Birth:_____

Address: _____ Town: _____ State: _____ Zip: _____

Cell Phone: _____ Occupation: _____

Email Address:

_____

Emergency Contact:

_____

Would you like to receive occasional email updates? ☐ Yes ☐ No Thanks

How did you hear about us?

_____

About You

Please list all medications currently being taken, including prescriptions, over the counter, and topical:

_____

Please list any accidents or surgeries from the past year:

_____

Are you currently pregnant or nursing? How far along?:

_____

Do you have a history of any of the following conditions? (Please circle)

Arthritis	Circulatory Problems	Diabetes	Glasses
Headaches/Migraines	High Blood Pressure	Irregular Digestion	Chronic Pain
Osteoporosis	Sciatica	Sleep Problems	Varicose Veins
Heart Disease	Swollen Glands	Allergies	Other:

Anything additional information you would like us to know?

_____

Waxing

Have you ever received a professional waxing service? What area?

_____

Did you have any adverse reactions including ingrown hairs, swelling, or bruising? If so, please explain:

_____

Please list any prescription medications you are using for acne or anti-aging, and the last time they were used (ie. Actuate, Renova, Retin A, Salicylics, or Glycolics):

_____

Please list any allergies or sensitivities, including fragrances:

_____

Massage Therapy

Have you received massage therapy or other bodywork before? How often?

_____

Please list any implants you currently have:

_____

What level of pressure do you prefer?

_____

Please list any areas you would like your therapist to focus on today:

_____

List any areas that you would like your therapist to avoid:

_____

Please list any allergies or sensitivities, including fragrances:

_____

What are your goals for this massage session? (Please circle)

Relaxation	Pain Relief	Stress Reduction	Other:

Skincare

What are your specific concerns and goals for your skincare session(s)?

_____

What is your daily home care regimen?

_____

Please list any prescription medications you are using for acne or anti-aging, and the last time they were used (ie. Acutate, Renova, Retin A, Salicylics, or Glycolics):

_____

Have you ever had (please circle)

Microdermabrasion Chemical Peel Botox/Fillers Other Resurfacing Treatments

Have you had any facial surgery?

_____

Do you have a pacemaker or any medal pins in your body?

_____

Are you under the care of a dermatologist?

_____

Do you have any known skin sensitivities or irritants?

_____

I have completed this form to the best of my knowledge. I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation, and improvement of circulation and energy flow. Massage Therapists and Estheticians do not diagnose illness, disease, physical or mental disorders, prescribe treatments of pharmaceuticals, or perform spinal manipulations. It is very clear to me that treatments received at Del Soul Spa are not a substitute for medical exam or diagnosis and that it is recommended that I see a physician for any ailments that I may have. I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health.

If I am unable to keep an appointment, I agree to cancel the appointment at least 24 hours in advance. Appointments cancelled with less than 24 hours notice Del Soul Spa reserves the right to charge a fee equal to 50% of the value of the scheduled service. No call, no shows will be charged 100% of the value of the scheduled service.

Signature _____ Date _____