



My Red Bow, Spa Treatments

Skin Care Confidential Client Intake Form

First & Last Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Phone# _____

Can we send promotional information? Y / N If YES - E-mail or Mail

Referred by/How did you hear about us? _____

Birthday: _____

Occupation: _____ Have you had a massage before?: Y / N

If yes, what type of massage _____

Are you currently seeing a health care provider. Y / N

Are you taking any prescribed types of medication. Y / N

If Yes please list types of medication and reasons _____

Please check any of these conditions you have below.

- | | | | |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes | <input type="checkbox"/> blood clots | <input type="checkbox"/> broken/dislocated bones |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> cancer | <input type="checkbox"/> chronic pain | <input type="checkbox"/> constipation/diarrhea |
| <input type="checkbox"/> auto immune* | <input type="checkbox"/> hepatitis | <input type="checkbox"/> skin condition | <input type="checkbox"/> stroke |
| <input type="checkbox"/> surgery | <input type="checkbox"/> tmj disorder | <input type="checkbox"/> depression | <input type="checkbox"/> panic or other disorder |
| <input type="checkbox"/> diverticulitis | <input type="checkbox"/> headache | <input type="checkbox"/> heart condition | <input type="checkbox"/> back problem |
| <input type="checkbox"/> scoliosis | <input type="checkbox"/> insomnia | <input type="checkbox"/> pregnancy | <input type="checkbox"/> muscle strain/sprain |
| <input type="checkbox"/> seizures | <input type="checkbox"/> whiplash | <input type="checkbox"/> high blood prssure | |

Please elaborate on any above conditions. _____

Consent to treat a minor: I, _____, am the parent or legal guardian and consent to allow **My Red Bow, Spa Treatments** and it's independent practitioners to administer bodywork to my child, _____, who is under the age of 18.

Do you have any of the following today:

- | | | | |
|--|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> skin rash | <input type="checkbox"/> cold/flu | <input type="checkbox"/> open cuts | <input type="checkbox"/> severe pain |
| <input type="checkbox"/> anything contagious | <input type="checkbox"/> injuries/bruises | | |

Do you have any allergies to:

food (nuts, etc)

medications

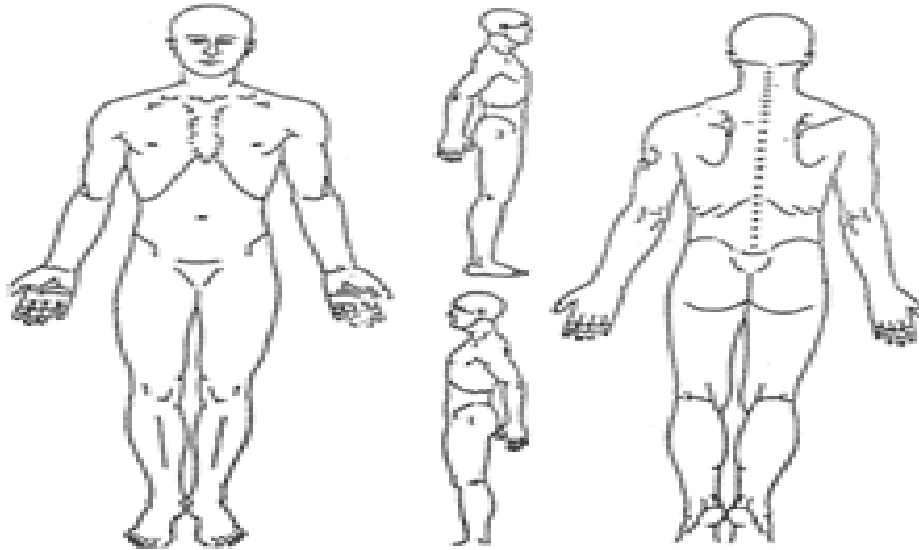
allergies (dust, pollen, fragrances)

reaction to skin care products

Please give details to any of the above allergies _____

Are you wearing: contacts lens hearing aid hair piece

Please indicate with an (X) any areas of discomfort.



Do you have questions, comments, or concerns you would like to discuss? _____

I understand the treatment(s) I am about to receive is provided by a licensed technician who has undergone all the current state, county, city, and educational requirements necessary to perform these treatments. If I notice discomfort, pain, etc., I will notify my therapist immediately. I also understand my treatments are not to take the place of a doctor's examination, diagnosis, prescription, or treatment of a physical or mental illness or condition I knowingly or unknowingly currently have. I have to the best of my ability listed all known conditions, injuries, treatments, medications, past or present. My Red Bow, Spa Treatments and it's independent contractors will be considered faultless for contraindications or injuries, whether physical or mental, by me not sharing my medical history. I will not hold My Red Bow or affiliates responsible for any reactions to massage service due to my mental, medical, or health conditions. I agree to keep any technician affiliated with My Red Bow, Spa Treatments up to date on my health. **Proper draping is required and any illicit or sexually suggestive remarks, advances, and/or innuendos made by me will result in immediate termination of my session.** Thank you for your time and patience in filling this form out.

Client Signature: _____ **Date** _____

Practitioner Signature: _____