



Massage Therapy & Day Spa

# Client Info Sheet

Please print and fill out in detail  
Today's date: \_\_\_/\_\_\_/2009

## Client Information

Full Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

Email Address \_\_\_\_\_

Gender  
 M  F

Date of Birth:  
\_\_\_\_/\_\_\_\_/\_\_\_\_

## How did you hear about us?

Friend/Spouse Name: \_\_\_\_\_

Radio Station : \_\_\_\_\_  Mail Coupon

Gift Certificate  Phone Book

ColumbineDaySpa.com  Internet

Other: \_\_\_\_\_  Newspaper

## Conditions:

- Arthritis  When \_\_\_\_\_
- Asthma  When \_\_\_\_\_
- Autoimmune Disorder  When \_\_\_\_\_
- Back Pain  When \_\_\_\_\_
- Blood Press.  Hi  Lo  When \_\_\_\_\_
- Blood Sugar  Hi  Lo  When \_\_\_\_\_
- Bruise Easily  When \_\_\_\_\_
- Bursitis  When \_\_\_\_\_
- Cancer  When \_\_\_\_\_
- Chest Pain / Tightness  When \_\_\_\_\_
- Diabetes  When \_\_\_\_\_
- Fainting Spells  When \_\_\_\_\_
- Fibromyalgia  When \_\_\_\_\_
- Fractures  When \_\_\_\_\_
- Heart Condition  When \_\_\_\_\_
- Headaches/Migraines  When \_\_\_\_\_
- Hip/Leg Pain  When \_\_\_\_\_
- Jaw  When \_\_\_\_\_
- Neck Pain  When \_\_\_\_\_
- Sciatica  When \_\_\_\_\_
- Scoliosis  When \_\_\_\_\_
- Shoulder/Arm Pain  When \_\_\_\_\_
- Skin Lesions/  
Inflammation  When \_\_\_\_\_
- Smoker  When \_\_\_\_\_
- Surgery  When \_\_\_\_\_

Are You Pregnant?  No  Yes # Months \_\_\_\_\_

List All Allergies: \_\_\_\_\_

List any Medical Conditions: \_\_\_\_\_

NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY & ZIP \_\_\_\_\_  
 PHONE \_\_\_\_\_

DATE OF 1<sup>ST</sup> VISIT \_\_\_\_\_  
 AGE \_\_\_\_\_  
 REFERRED BY \_\_\_\_\_

**General Health Record**

Are you a sun lover?	Yes [ ] No [ ]	Have you been exposed to the sun or sun beds recently?	Yes [ ] No [ ]
Are you pregnant?	Yes [ ] No [ ]	If yes, explain _____	
Any menopause problems?	Yes [ ] No [ ]	On the Pill? Yes [ ] No [ ]	If yes, since when? _____
Are you:		Hormones? Yes [ ] No [ ]	Herpes/Cold Sores Yes [ ] No [ ]
*Claustrophobic?	Yes [ ] No [ ]	Epileptic? Yes [ ] No [ ]	Hemophiliac? Yes [ ] No [ ]
*Asthmatic?	Yes [ ] No [ ]	Diabetic? Yes [ ] No [ ]	Arthritic? Yes [ ] No [ ]
Any heart problems?	Yes [ ] No [ ]	Hepatitis? Yes [ ] No [ ]	Pacemaker? Yes [ ] No [ ]
Do you wear contacts?	Yes [ ] No [ ]	Do you smoke? Yes [ ] No [ ]	
Any skin problems? _____	Yes [ ] No [ ]	Any pins, metallic or cosmetic implants?	Yes [ ] No [ ]
Any allergies? _____	Yes [ ] No [ ]	If yes, explain _____	
Any skin cancer? _____	Yes [ ] No [ ]	If yes, explain _____	
Any recent surgery? _____	Yes [ ] No [ ]	If yes, explain _____	
Any plastic surgery? _____	Yes [ ] No [ ]	If yes, explain _____	
Are you currently taking any medication?	Yes [ ] No [ ]	Do you have any history of acne or periodic breakouts?	Yes [ ] No [ ]
Do you use Retin A?	Yes [ ] No [ ]	Have you recently had Botox, Laser resurfacing?	Yes [ ] No [ ]
* For what purpose? _____		]Do you use depilatories or wax on your face?	Yes [ ] No [ ]
Have you ever used Accutane?	Yes [ ] No [ ]		
If yes, When? _____			
Do you use Glycolic Acid products?	Yes [ ] No [ ]		
Have you ever had an Acid Peel?	Yes [ ] No [ ]		

**General Skin Care Information**

How do you cleanse your face? [ ] Soap [ ] Cleanser [ ] Other Please specify brand \_\_\_\_\_

Do you use any home treatment products? Yes [ ] No [ ] If yes, what brand? \_\_\_\_\_

What is the purpose of this visit?  
 \_\_\_\_\_

What kind of improvement would you like to see on your skin?  
 \_\_\_\_\_

**Skin Analysis**

Skin Texture	[ ] Fine	[ ] Medium thickness	[ ] Thick	[ ] Very Thick
Complexion Color	[ ] Pale	[ ] Healthy	[ ] Muddy	[ ] Waxy
	[ ] Olive	[ ] Suntanned	[ ] Ebony	
Dehydrated	[ ] Superficially	[ ] Deeply		
Active Sebaceous Glands	[ ] Oily	[ ] Asphyxiated	[ ] Seborrheic	[ ] Comedogenic
	[ ] Dilated Pored	[ ] Acne	[ ] Cystic Acne	
Insufficient Gland Secretion	[ ] Dry	[ ] Alipoid		
Skin Type	[ ] Normal Skin	[ ] Partially Oily		
Circulation Problems	[ ] Couperose	[ ] Erythrose	[ ] Rosacea	
*Precise area	[ ] Nose	[ ] Cheeks	[ ] Chin	[ ] Forehead
	[ ] Entire Face			
Muscle Tone	[ ] Good Face Contour	[ ] Medium Lack of Tone	[ ] Fallen	
Aging Signs	[ ] Deep Expression Lines	[ ] Crow's Feet	[ ] Fine Lines All over Face	
	[ ] Crepeness Around Eyes		[ ] Falling Eyelids	
Other Problems	SCARS [ ] Light	[ ] Medium	[ ] Deep	
	PIGMENTATION [ ] Light Freckles	[ ] Dark & Heavy Freckles	[ ] Pregnancy Mask	
	[ ] Birthmarks	[ ] Brown Patches	[ ] Photosensitivity	
	[ ] Double Chin	[ ] Deteriorated Neck	[ ] Milium	[ ] Sensitivity around Mouth

