

THE WOODHOUSE

day spa®

The following questionnaire provides the information that will enable us to provide you services and treatments safely and effectively. All information is completely confidential, and vital for your protection as well as ours. Thank you for your cooperation.

First Name: _____ Middle: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Occupation: _____ Age: _____ Male Female Email: _____

Date of Birth: _____ Wedding Anniversary, if married: _____

Referred By: _____

Would you like to receive specials and our newsletter by email: Yes No

MEDICAL HISTORY:

Please list all medication you take internally: _____

Do you have health problems? (Please check all that apply currently or in your past)

<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Cancer/Cancer Therapy	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pregnant/Lactating	<input type="checkbox"/> Back/Neck Pain
<input type="checkbox"/> Skin Condition	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Hepatitis	

Do you have any other medical condition we need to be aware of? _____

Have you ever experienced an allergic reaction to any drug or other substance? (If yes, please explain): _____

SKIN CARE/WAXING/HYDROTHERAPY:

What skin care line are you using? _____ Do you wear makeup? _____ What brand? _____

Please explain how you take care of your skin daily/nightly? _____

Are you claustrophobic? yes no

Are you using Retin-A? yes no

Are you taking Accutane? yes no

Are you under the care of a Dermatologist? yes no

Have you ever had an allergic reaction to a cosmetic product? yes no (If yes, please explain): _____

What is your specific concern about your skin? _____

What are the end results that you are expecting to accomplish? _____

Spa, facial and massage treatments are relaxing, but are not replacements for medical attention. No diagnosis will be made, nor medication given or prescribed. I consent to any of the services and treatments that I have chosen at THE WOODHOUSE DAY SPA®.

Client Signature: _____ Date: _____

MASSAGE THERAPY

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to providing service.

Yes No Have you ever experienced a professional massage or bodywork session? How recently? _____

If yes, what did you like about it? _____ What didn't you like about it? _____

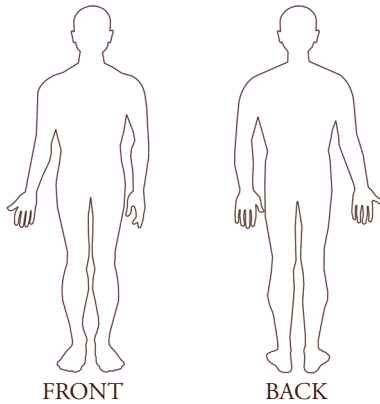
If yes, do you like light, moderate, or deep pressure? _____

Yes No Have you been in an accident or suffered any injuries? (If yes, please explain): _____

Do you have tingling or numbness in a specific area?

Yes No

Please mark, with an 'X', any areas of pain, tightness or spasm.



Swedish massage techniques including effleurage, petrissage, percussion, friction, and vibration (shaking/jostling) may be used during the session. Acupressure, Reflexology, and/or Myotherapy (trigger point therapy) may also be used if deemed appropriate for treatment by the therapist.

All parts of the client's body may be massaged, excluding the male and female genitals and female breasts. Any areas of the body that the client wishes to be avoided during the massage session, or that may need to be avoided due to a contraindication will be listed below. Any areas of the body that either the client or the therapist considers to need additional massage therapy may be indicated below.

Areas of the body to be avoided: _____ Reason: _____

Areas of the body to administer additional massage therapy: _____

Reason: _____

Draping will be used during the session unless otherwise agreed to by both the client and the therapist. At any point a guest is uncomfortable, they may request to stop the service.

I, the client, understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. In consideration of using the spa facilities and/or taking part in spa treatments/programs, I agree, to the fullest extent permitted by law, to forever release, indemnify, defend and hold harmless the spa, its subsidiaries and affiliates, their respective agents, officers, directors, owners, contractors and employees (collectively the "Released Parties") from any and all claims and causes of action which I (or the below-mentioned minor) might otherwise have or be entitled to assert as a result of or related to any physical injury or otherwise, including without limitation death or property damage or loss sustained in connection with my use (or the below mentioned minor's use) of the spa facilities or participation in any spa program or treatment, including, without limitation, claims and causes of action based on negligence, breach of warranty or breach of contract. I also agree to indemnify, defend, and hold harmless the Released Parties from any and all claims brought by third parties arising out of any (or the below-mentioned minor's) acts, errors, or omissions.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to Treatment of Minor Under the Age of 17: By my signature below, I hereby authorize a Registered Licensed Massage Therapist to administer massage or bodywork therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____