雨 Rain Salon & Spa

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Massage & Bodywork Questionnaire

Name ______________________________________

Occupation __________________________________ Age _______ ☐ Male ☐ Female

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 service being provided.

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

Do you frequently suffer from stress? Yes No
Do you have diabetes? Yes No
Do you experience frequent headaches? Yes No
Are you pregnant? Yes No
Do you suffer from arthritis? Yes No
Are you wearing contact lenses? Yes No
Are you wearing dentures? Yes No
Do you have high blood pressure? Yes No
If "yes" to previous question,
are you taking medication for this? Yes No
Do you suffer from epilepsy or seizures? Yes No
Do you suffer from joint swelling? Yes No
Do you have varicose veins? Yes No
Do you have any contagious disease? Yes No
Do you have osteoporosis? Yes No
Do you have allergies? Yes No
Do you bruise easily? Yes No

Have you had any broken bones in the past 2 years? Yes No
Have you been in an accident or suffered any injuries
in the past two years? Yes No
Do you have tension or soreness in a specific area? Yes No
If "yes" to previous question please specify:
____
____
____
Do you have cardiac or circulatory problems? Yes No
Do you suffer from back pain? Yes No
Do you have numbness or stabbing pains anywhere? Yes No
Are you sensitive to touch or pressure in any area? Yes No
Have you ever had surgery? Explain below. Yes No
Do you have any other medical conditions or are you
taking any medications I should know about? Yes No
Comments
____
____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnosed, prescribe, or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I fail to do so. I also understand that any illicit or sexually 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.

Client Signature ________________________________ Date __________________________

Consent to Treatment of a Minor: By signature below, I hereby authorize Rain Salon & Spa and its practitioners to administer massage/bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian ___________________________________ Date __________________________

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Skin Care Questionnaire

How would you describe your skin? ☐ Normal ☐ Dry ☐ Oily

What is the primary concern with your skin?

- ☐ Fine lines and/or signs of aging
- ☐ Discoloration and dark spots
- ☐ Maintain healthy looking skin
- ☐ Acne, breakouts, and/or congestion
- ☐ Skin sensitivity

What products are you currently using?

____

What is most important to you when choosing your skin care products?

____

Have you had any facial medical procedures?

____

Have you had any recent illness, injuries, or broken bones? Do you have any allergies or sensitivities?

____

Are you currently under the care of a medical professional?

____

Are you currently taking any medications or supplements?

____

Female guests - Are you pregnant? If yes, what week? Have you had any complications or have you been told you have a high risk pregnancy?

____

Are there any other health or medical concerns of which we should aware?

____

What expectations do you have for your treatment today?

____

Are you interested in adding any waxing services such as brow, lip or chin to your appointment today? ____________________

We are here to nurture you, if you are feeling any discomfort whatsoever with temperature, pressure or anything else, please feel comfortable letting us know.

It is my choice to receive massage therapy, spa therapy and/or esthetic treatments. I understand that any information given is strictly confidential and will be used for no other purpose than to assist the massage therapist and/or esthetician in providing a suitable treatment which would take into consideration to my specific requirement. I also understand that failure on my part to disclose information should result in injury and/or illness and I hereby release Rain Salon & Spa, Aveda Corporation and its parent company from any claims resulting from such. Any information provided to me by the massage therapist or esthetician is for general educational purposes only and is not intended for any medical purpose.

Guest Name ____________________________________ Signature ______________________________________

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Waxing Questionnaire

Name ______________________________

Occupation ______________________________ Age ________ ☐ Male ☐ Female

We would like to inform you of any potential risks that may occur from waxing.
As always you are taking a risk when waxing. Waxing not only removes unwanted hair but also the top layer of the skin, known as the Epidermis. Because of this, it is important that you read the following information:

Acutane Most physicians advise against facial waxing of any kind; up to six months after use.

RetinA Renova, Differin, and prescription strength AHA's are not recommended with waxing.

Side Effects: Because most medications thin the skin, waxing is not advised while taking medications which may lead to unnecessary tearing of the skin. This includes not only the Epidermis, but the Dermis as well.

Please check which of the following apply:

- ☐ Varicose Veins
- ☐ Poor Circulation
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Skin Disease
- ☐ Warts
- ☐ Phlebitis
- ☐ Psoriasis

- ☐ Edema (Swelling of the legs)
- ☐ Moles
- ☐ Recent Scar Tissue
- ☐ D Glycolic Acis
- ☐ Undiagnosed Lumps or Bumps
- ☐ Hypersensitive Skin
- ☐ Sunburn
- ☐ Pregnancy
- ☐ Prescribed Medication

Do you use any of the following?

- ☐ RetinA or Renova
- ☐ Accuatane
- ☐ Glycolic Acid
- ☐ Products containing Alpha Hydroxy Acids
- ☐ Have you previously had waxing treatments

I understand that I am responsible for notifying the wax technician should any of the above information change prior to any waxing treatment.

Signature ______________________________ Date ______________________________