

## 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 \_\_\_\_\_

## 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?

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

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Have you had any facial medical procedures?

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

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Are you currently under the care of a medical professional?

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Are you currently taking any medications or supplements?

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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?

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

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What expectations do you have for your treatment today?

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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 \_\_\_\_\_

## 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:

- |   |   |
|---|---|
| <input type="checkbox"/> Varicose Veins   | <input type="checkbox"/> Edema (Swelling of the legs) |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Moles                        |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Recent Scar Tissue           |
| <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> D Glycolic Acis              |
| <input type="checkbox"/> Skin Disease     | <input type="checkbox"/> Undiagnosed Lumps or Bumps   |
| <input type="checkbox"/> Warts            | <input type="checkbox"/> Hypersensitive Skin          |
| <input type="checkbox"/> Phlebitis        | <input type="checkbox"/> Sunburn                      |
| <input type="checkbox"/> Psoriasis        | <input type="checkbox"/> Pregnancy                    |
|   | <input type="checkbox"/> Prescribed Medication        |

Do you use any of the following?

- RetinA or Renova  
 Accutane  
 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 \_\_\_\_\_