

# Awakening Spa Health History Form

If you are experiencing any Covid-19 symptoms, or have been in contact with persons with virus in past 14 days, please cancel your appointment

Name \_\_\_\_\_ Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Birthday (mm/dd/yr) \_\_\_\_\_

Tell us about you! **Are you:** Local \_\_\_ Visitor \_\_\_ **Are you:** Returning guest \_\_\_ New guest \_\_\_

How did you hear about us? \_\_\_\_\_

Have you ever experienced a spa treatment before? Yes No

Please list any allergies, and the reactions you've had:

\_\_\_\_\_

Please list current medications: \_\_\_\_\_

## Do you have any of these health conditions? (Please check all that apply.)

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Systemic Disease
<input type="checkbox"/> Excessive bruising	<input type="checkbox"/> Acute Injury
<input type="checkbox"/> Seizures	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes/Cold sores
<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Surgery in past year
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Severe Headaches
<input type="checkbox"/> Acne/Skin condition	<input type="checkbox"/> Think you're Pregnant? How far along? _____
<input type="checkbox"/> Nail Fungus	<input type="checkbox"/> Alcohol Consumption Today Yes No
<input type="checkbox"/> Spinal Problems	<input type="checkbox"/> Sunburn? Where? _____
<input type="checkbox"/> Radiating Pain	<input type="checkbox"/> Open Wounds
Other _____	

## **Would you like to add any of the following enhancements to your service (please check):**

Aroma Therapy \$10 \_\_\_ Foot Treatment \$15 \_\_\_ Scalp Massage \$15 \_\_\_ Bio Freeze \$10 \_\_\_

Paraffin \$15 \_\_\_ Hot Stone \$35 \_\_\_ Exfoliation Package \$25 \_\_\_ Face Massage \$15 \_\_\_

Take Home Bath Salt \$15 \_\_\_ Dry Brush \$15 \_\_\_ Custom Shower Exfoliate \$15 \_\_\_

## **If time allows I would like to add on..... (Please check your choices. Additional costs apply.)**

Facial \_\_\_ Body treatment \_\_\_ Aroma Bath \_\_\_ Waxing \_\_\_

Please silence all electronic devices and refrain from holding phone conversations. We appreciate you using your spa voice while visiting our facility. I declare that all information provided on this form is complete and true to the best of my Knowledge. I hereby release The Awakening Spa and their respective officers, directors, shareholders and employees and waive any and all claims, liabilities, or damages for personal injuries that I may experience directly or indirectly from receiving Spa related treatments, or by utilizing Spa facilities.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Awakening Esthetics Intake Form

If you are experiencing any symptoms of Covid-19, or have been in contact with persons with virus in last 14 days, please cancel your appointment

Name \_\_\_\_\_ Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Birthday (mm/dd/yr) \_\_\_\_\_

Tell us about you! Are you: Local \_\_\_ Visitor \_\_\_ / Are you: Returning Guest \_\_\_ New Guest \_\_\_

How did you hear about us? \_\_\_\_\_

Have you ever experienced a spa treatment before? Y/N

Are you taking any medications? (Topical/oral) Please list \_\_\_\_\_

Please list any allergies/reactions: \_\_\_\_\_

What type of skin do you think you have? (Circle all that apply)

Oily Dry Dehydrated Combination Aging Acne Sensitive Normal

How do you care for your skin? (Circle all that apply)

Cleanse Exfoliate Masks Moisturize Serums toner SPF What Brands of products do you use?  
\_\_\_\_\_

Do you have any skin conditions, open cuts or sores? \_\_\_\_\_ Are you wearing contacts, false lashes? Y/N  
Do you visit a dermatologist? Y/N

Please Circle Services or treatments you have had... Chemical peel Microdermabrasion Laser Fillers Restylane Retin -A

Would you like Extractions performed? Y/N

What are your Goals/expectations for today's service? \_\_\_\_\_

Do you have sunburn? Yes \_\_\_ No \_\_\_ If yes where? \_\_\_\_\_

Would you like to add any of the following enhancements to your service (please check):

Eye Treatment \$15\_\_\_ Aroma Therapy \$10\_\_\_ Foot Treatment \$15\_\_\_ Scalp Treatment \$15\_\_\_

Exfoliation Package \$25\_\_\_ Dry Brush \$15\_\_\_ Hot Stone Therapy \$15\_\_\_

Custom Shower Exfoliate \$15\_\_\_ Cold Stone Therapy \$15\_\_\_ Hand Treatment \$10\_\_\_

Algae Mask \$20\_\_\_ Lip Hydration Treatment \$20\_\_\_

If time allows I would like to add..... (Please check your choices. Additional costs apply.)

Waxing\_\_\_ Massage\_\_\_ Body Treatment\_\_\_ Aroma Bath\_\_\_

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Signature \_\_\_\_\_

Date \_\_\_\_\_