

# De Jolie Salon & Spa

Name \_\_\_\_\_ DOB \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail: \_\_\_\_\_

In case of emergency: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Referred By: \_\_\_\_\_

## **General & Medical Information**

Occupation \_\_\_\_\_  Male  Female

Yes  No Have you ever experienced a professional massage or facial session? How recently? \_\_\_\_\_

*If you answer "yes" to any of the following questions, please explain as clearly as possible.*

Yes  No Are you pregnant? If so, How far along? \_\_\_\_\_

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 arthritis?

Yes  No Do you bruise easily?

Yes  No Are you very sensitive to touch or pressure in any area?

Yes  No Do you have any allergies? Are you allergic to any oils or lotions?

Yes  No Have you ever had surgery?

Explain: \_\_\_\_\_

Yes  No Do you have tension or soreness in a specific area?

Please Specify: \_\_\_\_\_

Yes  No Do you have any medical condition, or are you taking any medications I should know about? For example: diabetes, seizures, contagious diseases, high blood pressure ect.

\_\_\_\_\_

Please list all current conditions/medications:

Please mark the areas you DO NOT want the massage therapist to work on:

Scalp  Face  Neck/Shoulders/Chest (upper area of chest for women/pectoral area included for men)

Arms  Hands  Abdomen  Front and Back of Legs

Feet  Back  Glutes

## **Your Health**

Yes  No Within the last year, have you been under a dermatologist or any other physicians care?

Yes  No Within the last nine months, have you undergone any surgery?

Yes  No Do you have metal implants, a pacemaker or body piercings?

Yes  No Do you have any special skin problems pertaining to your face or body?

Do you use  Accutane  Retin A  Renova  Adapalene or any other prescription skin products? \_\_\_\_\_

Are you currently using any products that contain the following ingredients?

- Glycolic acid**  **Lactic acid**  **Exfoliating scrubs**  
 **Hydroxy acid product**  **Vitamin A derivatives (retinol)**

- Yes**  **No** Do you burn easily in moderate sunlight?  
 **Yes**  **No** Do you experience oily shine in the day?  
 **Yes**  **No** Do you have a tendency to redness?  
 **Yes**  **No** Do you ever experience skin breakouts?  
 **Yes**  **No** Do you blush easily when nervous

Do you ever experience these conditions?  **Flakiness**  **Tightness**  **Obvious dryness**

Have you ever had a reaction to any of the following?

- Cosmetics**  **Medicine**  **Iodine**  **Pollen**  **Food**  
 **Hydroxy Acid**  **Animals**  **Fragrance**  **Sunscreens**

Rate your level of stress on a scale from 1 to 4 (1=low stress, 4=high stress) \_\_\_\_\_

List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly

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What skin care products are you currently using?

Face:  Soap  Cleanser  Toner  Moisturizer  Masque  Exfoliator  Eye products

Body:  Soap  Shower Gel  Scrubs  Oil  Body Moisturizer  Depilatory Products  Self tanners

I understand that the massage/facial I will be receiving from De Jolie Spa is for the purpose of relaxation, stress reduction, relief from muscular tension or spasm, and/or well being. I understand that the massage/skin therapist does not diagnose illness, disease, or any further physical or mental disorders. As such, the massage/skin therapist does not prescribe medical treatment or pharmaceuticals, nor does he or she perform spinal manipulations. I understand that massage/facial is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical ailments that I may have.

I acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. I understand that it is my responsibility to inform the massage/skin therapist of any changes to this information. I understand that if I experience any unusual discomfort and/or pain during my session it is my responsibility to inform the massage/skin therapist so that he/she can adjust the pressure or technique being used.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature \_\_\_\_\_ Date: \_\_\_\_\_