

Bloom Skin Spa inc.

CLIENT PROFILE

(PLEASE PRINT)

DATE: ____ / ____ / ____ NAME: _____

SALUTATION: (Mr. / Mrs. / Ms. / Miss / Dr.) GENDER: M / F MINOR: Y / N

BIRTHDAY: ____ / ____ / ____ (the year is optional)

ADDRESS: _____ APT/CONDO # _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: cell: (____) _____ - _____ home: (____) _____ - _____
work: (____) _____ - _____ email: _____@_____

OCCUPATION: _____

I wish to receive *Bloom Skin Spa* newsletter and/or internet special notices Y / N

EMERGENCY CONTACT

NAME: _____ RELATION: _____

PHONE: (____) _____ - _____ OR (____) _____ - _____

DERMATOLOGIST/PHYSICIAN

NAME: DR. _____ PRACTICE: _____

PHONE: (____) _____ - _____ circle one: FAMILY / DERM / OTHER

HOW DID YOU HEAR ABOUT *Bloom Skin Spa*

NEWSPAPER YELLOW PAGES MAILER FLYER

COUPON MENU BUSINESS CARD REFERRAL

WEB LINK SEARCH ENGINE INTERNET ADVERTISMENT

WORK NEARBY GIFT CERTIFICATE OTHER _____

BLOOM SKIN SPA, 547 KEISLER DRIVE, SUITE 103, CARY, NC 27518 - (919) 454-4997 – BLOOMSKINSPA.COM

Bloom Skin Spa inc.

HEALTH HISTORY FORM (PLEASE PRINT)

NAME: _____

DO YOU HAVE A HISTORY OF ANY OF THESE HEALTH CONDITIONS?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Acute injury | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> or disorders |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Implants | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Arthritis / Bursitis | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Lupus | <input type="checkbox"/> Spinal problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Metal bone, pins | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> or plates | <input type="checkbox"/> Urinary or kidney problems |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches (chronic) | <input type="checkbox"/> Phlebitis | |
| <input type="checkbox"/> Cardiac problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychological problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiating pain | |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus problems | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin diseases | |
| <input type="checkbox"/> Hysterectomy | | | |

HAVE YOU EVER HAD THIS SERVICE BEFORE? YES / NO WHERE? _____

WHAT WAS YOUR EXPERIENCE?

- excellent good fair poor

INDICATE THE TYPE OF THERAPY RECEIVED AND THE FREQUENCY OF THIS MODALITY:

ARE YOU TAKING MEDICATIONS RIGHT NOW? YES / NO LIST: _____

ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE FOR ANY CURRENT CONDITION OR OTHER PROBLEM? YES / NO EXPLAIN: _____

PLEASE EXPLAIN OR LIST ANY SIGNIFICANT OTHER PROBLEMS: _____

ARE YOU PREGNANT, TRYING TO BECOME PREGNANT, OR LACTATING YES / NO

DID YOU CONSUME ANY ALCOHOLIC BEVERAGES PRIOR TO THIS SESSION? YES / NO

HAVE YOU EVER HAD SURGERY? YES / NO EXPLAIN: _____

DO YOU HAVE ANY PHYSICAL INJURIES OR DISABILITIES THAT REQUIRE SPECIAL ATTENTION

OR CARE DURING YOUR SERVICE? YES / NO EXPLAIN: _____

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Spa Body Treatments & Massage Informed Consent Form

(PLEASE PRINT)

NAME: _____

I understand that the massage and spa body treatments given by *Bloom Skin Spa* practitioners are for relaxation, stress reduction, and/or for increasing circulation. I further understand that *Bloom Skin Spa* practitioners do not diagnose illnesses disease or any other physical or mental disorders or prescribe medical or pharmaceutical treatment nor performs any spinal manipulations. It has been made clear to me that massage is not a substitute for a medical examination and/or diagnosis and it is recommended that I contact a licensed health care provider for any medical or health condition or physical ailments I might have. Because a therapist must be aware of existing physical conditions I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I also understand that as a result of this treatment, dehydration or flu-like symptoms may result. It is my choice to receive light massage with the body treatment and I have provided accurate information concerning all past and current health conditions. I agree to report any changes in my health as they arise.

My session may involve the use of oils, lotions, and possibly hot and/or cold towels or stones necessitating the need for me to remove most of my clothing. During this time, I understand I will be provided with disposable garments or wear my own under garments and also draped appropriately with linens for warmth and privacy. Only the specific area being treated will be undraped, but I will dress to my comfort level. If a session necessitates removal of clothing, and I would prefer to remain clothed, I WILL INFORM MY PRACTITIONER.

I understand that any illicit or sexually suggestive remarks or advances made

- will result in immediate termination of the session
- the authorities will be called and a police report will be filed
- you will be prosecuted to the fullest
- a restraining order will be filed
- the entire session will be paid for in full

Patient Signature _____

Please print name _____

Date ____/____/____

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