



Listed: _____ B&B _____ B&Brrgc# _____ AP _____ AP _____ AP _____

Please fill out all Massage Therapy information as legibly, accurately and thoroughly as possible.
 We accept Cash and Credit Card payments (with photo identification ONLY) Sorry, NO Checks Accepted!
Fill out highlighted areas completely.

Your Name: _____ **Name of Person You Arrived With:** _____

Street: _____ **City, State** _____ **Zip Code** _____

Phone #'s Cell: () _____ **Other:** () _____ **Occupation:** _____

e-mail address: _____ **Date of Birth:** _____

1. How did you discover us? (Google, Heights Massage & Day Spa Website, Yahoo, CitySearch) Were you referred by anyone? Give us a name and their email address/phone number we can thank.

2. Have you received massage or bodywork elsewhere before? (If yes, where did you go and how was it?)

3. What kinds of activities do you do daily? (i.e. sit, computers, run, work-out, driving, mouse-potato, walk, mixed)

4. What (specifically) would you like to receive from this massage? Would you like me to **focus** on any specific area?

5. What type of massage pressure do you typically enjoy or would enjoy today? (circle best choices for you)

Light Medium Firm Mixed Deep Tissue (\$20. additional per hour)

6. Would you like me to **avoid** any specific area for health reasons, or any areas you simply do not wish to have massaged, or areas you **DO NOT** like to be massaged? Please circle: Stomach – Ears – Eyes – Face – Feet – Other: _____

Your Health Information:

1. Emergency Contact Name, #, and their relationship to you: _____

2. Do you have any conditions that may require a doctor's note? Yes No (please circle)

3. Is it okay for me to contact your healthcare provider if necessary? Yes No (please circle) If yes, put provider's information below.
 My healthcare provider's name is: _____

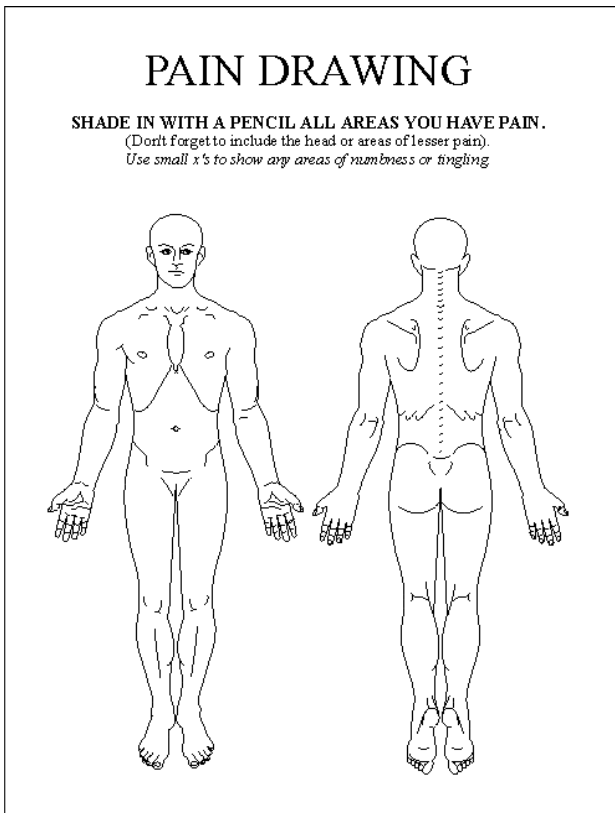
4. Do you have, have you had, or are you any of the following (please circle and/or give date):

<ul style="list-style-type: none"> -Heart Conditions -Smoker -Diabetic -Contact Lenses or Hearing Aid -Contagious Disease -Skin Infection -High/Low Blood Pressure (circle which one) -Food Allergies -Cancer -Currently Pregnant 	<ul style="list-style-type: none"> -Epileptic/Seizures -Frequent Headaches -Varicose Veins -Nausea -Dementia -Car Accident - Approx. Date: -Taking Vitamins Now? -On Medication Now? List meds: -Other Conditions:
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(please fill out and sign backside of this page too)



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Client Agreement:

PLEASE read the following statement and sign and date on the line to indicate that you have read the statement and understand it.

Massage is a service intended for enhancing your health and quality of life. If at any time you (or the therapist) are uncomfortable with the massage session, please inform the therapist and s/he will gladly rectify the problem, including ending the session if you (or the therapist) wish. In all massage modalities & sessions appropriate draping will be used for your comfort level. At no time during the massage will the therapist massage the breasts area of women, except in cases of scar tissue resulting from breast surgery and only with client's written consent.

I have completed this health form to the best of my knowledge. I understand that Massage Therapy and Bodywork services are a therapeutic health aid. They do not take the place of a physician's care when indicated. Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services. I release the Licensed Massage Therapist and Heights Massage & Day Spa from any responsibility for pre-existing conditions I have not revealed, or any consequential change to those conditions that arise subsequent to the treatment.

Types of massage techniques the therapist anticipates using during session include but are not limited to: Effleurage, Petrissage, Tapotement, Vibration, Friction, Swedish Gymnastics & massage, Yoga/Thai massage, Heated Stone Massage, Ah-Shiatsu Massage, AudioSensory Technique®, Orthopedic massage, myofascial release, sports massage, reflexology, neuromuscular therapy, Active Release Technique®, muscle/energy release techniques, trigger point release, mud & seaweed body treatments, inch-loss/detox wraps, lymphatic drainage, cranio-sacral therapy, Trigger Point Therapy, Deep Tissue Massage, Other: _____.

I understand my healing requires my active participation. I attest that the above is true and accurate to the best of my knowledge. I am responsible to pay for any Massage or Bodywork fees at the time of the session, unless other arrangements have been made. I agree to pay the total amount charged on my credit card (if I pay by credit card), according to card issuer agreement.

I attest that the above is true and accurate to the best of my knowledge.

Cancellation Policy:

Because we reserve the room and esthetician's time especially for you, please give us at least 24 hours notice to avoid paying the full value of the service for any cancellations or re-scheduling to a later time or date.

If you are moving your appointment earlier and we can accommodate your request there will be no charge. Because we may turn people away for the time we hold for you, the cancellation policy still applies even if you are making the appointment for the same day.

No-shows and same-day appointment cancellations less than 24 hours will be charged the full value of the treatment reserved, and/or any gift certificate or card associated with that appointment will count as services rendered.

A cancellation confirmation number will be given to you as your proof of exactly when your appointment was cancelled or changed.

I understand the above Heights Massage and Day Spa policies and agree to them.

Signature of person receiving massage/bodywork or legal guardian

Today's Date

Today's Therapist: _____



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SKINCARE Intake Form - Fill out form completely if you are receiving a facial or any type of skincare.
Please fill out all Skin Care information as legibly, accurately and thoroughly as possible.
Fill out highlighted areas completely.

Your Name: _____ **Name of Person You Arrived With:** _____

Street: _____ **City, State** _____ **Zip Code** _____

Phone #'s Cell: () _____ **Other:** () _____ **Occupation:** _____

e-mail address: _____ **Date of Birth:** _____

Please prioritize the cosmetic improvements you would like to see in your skin or list areas of concern:

1. _____ 2. _____ 3. _____

Are you interested in updating your homecare skin program? Yes No
Do you want us to tell you what we are using on your skin or do you prefer to enjoy the silence? **Yes, Tell Me** **No, I like Quiet**

Lifestyle:

What brand/type of skincare products are you currently using? _____

Do you use tanning booths? Yes No

Do you have permanent make-up? Yes No

Do you wear contacts? Yes No

Do you wax or use depilatories, electrolysis, or lasers for hair removal? Yes No

Do you spend most of your day outdoors? Yes No

What type of work do you do? _____

What oral/topical medications are you currently using? _____

What is your ethnic background? _____

Health History: (circle all that apply)

Skin Cancer History of Skin Cancer HIV Diabetes Heart Problems High Blood Pressure Hepatitis
Low Blood Pressure Sinus Problems/Asthma Chemo/Radiation Pacemaker/metal implants Neck/Spinal
injuries Lupus Hand/Arm Injuries Claustrophobia

Cold Sores, Fever Blisters Last outbreak: _____

Skin History: (circle all that apply)

Acne Hormonal Breakouts Rosacea Dermatitis/Eczema Psoriasis Pigmentation Issues
Scars/Keloid Scarring Hives Bruising Fine lines/Wrinkles Other: _____

Describe your skin type: _____

What temperature of water do you cleanse? Cold Warm Hot

Do you have any special areas of concern pertaining to your face or body? Specify: _____

Exfoliation and Bleaching History:

Are you currently using Accutane, Retin-A Renova, Differin, Tazorac, Adapalene or Avage? Yes No

Do you have regular Botox, Restylane, Juvederm or collagen injections? Yes No

Have you had recent facial surgery or laser resurfacing? Yes No

Have you ever had a chemical peel or a microdermabrasion treatment? If so, when was your last treatment? _____

Are you using any products that contain the following ingredients: (circle all that apply)

Glycolic Acid Lactic Acid Salicylic Acid Exfoliating Scrubs Hydroxy Acid products Sulfur
Cortisone Vitamin A derivatives (i.e. Retinol) Cleocin-T

Are you using any topical medications that cause you to peel? Yes No

Moisture – Hydration

How much plain water do you consume daily? _____

How many alcoholic beverages do you consume weekly? _____

Do you ever experience these conditions on your skin: flakiness tightness obvious dryness

What season of the year do you have these experiences of dryness: summer spring winter fall all times of year

(continued on next page)



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Oil Secretion:
 Do you ever experience oily shine during the day? Yes No Occasionally
 Is oil experience: All over Just the T-Zone

Nerve Activity:
 Do you drink caffeinated beverages Yes No Occasionally
 Do you smoke: Yes No
 Do you participate in vigorous aerobic activities or sports? Yes No
 What type of massage do you prefer? Light Medium Firm
 What is your pain threshold? Low Medium High

Capillary Activity:
 Do you burn easily in moderate sunlight? Yes No
 Do you blush easily when nervous? Yes No
 Do you have a tendency to redness? Yes No

Allergies:

Milk	Apples	Citrus/Grapes	Eggs	Aloe Vera	Aspirin	Hydroquinone	Perfumes	Sulfur
Pineapple/Papaya		Shellfish/Seaweed			Nuts	Retin-A/Retinoids		Alcohol Based Products
Pollen	Medicine	Iodine			Cosmetics	Essential Oils		Wheat

Known Allergies: _____
 Other Allergies: _____

Female Clients:

Regular Cycle	Irregular Cycle	Menopausal	Pregnant/Nursing	Peri-menopausal	Trying to become pregnant
Hysterectomy	Oral Contraceptives	HRT or any hormone balancing products?	PMS breakouts	Menstrual bloating or pain	
Do you experience Ingrown Hairs?		Yes No	Occasionally		
If so, where are they located?	Chin	Chest	Face	Body	

Male Clients:

Shave wet with razor	Shave dry with electric shaver	Shaving irritation/ingrown hair
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What shaving products are you currently using: _____

Skin Peel Policy:

This is to acknowledge that I, _____, have been given verbal instructions pertaining to my skin peel. I know that if I have any complications or allergic reaction I am to contact my facialist immediately.

Cancellation Policy:

Because we reserve the room and esthetician's time especially for you, please give us at least 24 hours notice to avoid paying the full value of the service for any cancellations or re-scheduling to a later time or date.

If you are moving your appointment earlier and we can accommodate your request there will be no charge. Because we may turn people away for the time we hold for you, the cancellation policy still applies even if you are making the appointment for the same day.

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Signature of person receiving massage/bodywork or legal guardian

Today's Date

Today's Skincare Specialist: _____