



Date: \_\_\_\_\_

## CLIENT INTAKE FORM - BODY TREATMENTS

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (H) \_\_\_\_\_ (C) \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Phone Number \_\_\_\_\_

### Health History - Check off conditions that apply to you.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Respiratory or Lung Disease |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Fungus                  | <input type="checkbox"/> Sciatica                    |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Sinus Conditions            |
| <input type="checkbox"/> Athlete's Foot         | <input type="checkbox"/> Herpes Simplex          | <input type="checkbox"/> Skin Conditions             |
| <input type="checkbox"/> Back or Neck Pain      | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Blood Clots            | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Sunburn                     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Kidney or Liver Disease | <input type="checkbox"/> Swollen Joints              |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Open Wounds             | <input type="checkbox"/> Varicose Veins              |
| <input type="checkbox"/> Carpal Tunnel          | <input type="checkbox"/> Plantar Fasciitis       | <input type="checkbox"/> Warts                       |
| <input type="checkbox"/> Chest Pains            | <input type="checkbox"/> Poor Circulation        | <input type="checkbox"/> Whiplash                    |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Rash                    |  |

### Circle yes (Y) or no (N).

- Do you have any current injuries? Y N Explain: \_\_\_\_\_
- Have you had any major surgeries? Y N Explain: \_\_\_\_\_
- Do you have any medical conditions? Y N Explain: \_\_\_\_\_
- Are you taking any medications? Y N Explain: \_\_\_\_\_
- Are you sensitive to aromatherapy? Y N
- Do you wear contact lenses? Y N
- Are you under a physicians care? Y N
- Are you taking blood thinning medication (for clotting)? Y N
- Do you bruise easily? Y N
- Have you been exposed to a communicable disease? Y N
- Are you pregnant? Y N How many weeks? \_\_\_\_\_

Please explain any other health concerns: \_\_\_\_\_

## Facial

Check off the skin types that apply to you.

- |                                 |                                      |   |   |
|---------------------------------|--------------------------------------|---|---|
| <input type="checkbox"/> Mature | <input type="checkbox"/> Oil         | <input type="checkbox"/> Sensitive              | <input type="checkbox"/> Acne/Problematic |
| <input type="checkbox"/> Dry    | <input type="checkbox"/> Combination | <input type="checkbox"/> Very Sensitive/Rosacea |   |

Check off the skin concerns that apply to you.

- |                                      |  |                                     |  |
|--------------------------------------|--|-------------------------------------|--|
| <input type="checkbox"/> Sun Damage  | <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Blackheads | <input type="checkbox"/> Dilated Capillaries |
| <input type="checkbox"/> Dehydration | <input type="checkbox"/> Rosacea           | <input type="checkbox"/> Whiteheads | <input type="checkbox"/> Uneven Texture      |
| <input type="checkbox"/> Sensitivity | <input type="checkbox"/> Enlarged Pores    | <input type="checkbox"/> Acne       | <input type="checkbox"/> Aging Skin          |

Are you currently using Retin A/alpha hydroxy acids?      Y   N

Please explain any information we should know that may effect your treatment: \_\_\_\_\_

## Wax

Have you had a professional waxing before?                      Y   N

Did you have a reaction to the waxing?                      Y   N      Explain: \_\_\_\_\_

Have you had a recent peel?    Y   N

Do you use alpha hydroxides, Retin A, Renova, Accutane or acne medication?   Y   N

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

## Gratuity

Gratuities for individual services are at the guest's discretion and are truly appreciated by the staff for outstanding service. If inclined, a 15-20% gratuity is customary. For multiple services or individual services with a group of people, a 20% gratuity will be applied to your bill.

## Waiver and Release

The undersigned \_\_\_\_\_ (print name), hereafter referred to as "Customer" does hereby waive and release, indemnify, hold harmless and forever discharge The Spa at Rhythm City Casino Resort, hereafter referred to as "Spa" and its agents, employees, officers, directors, affiliates, successors, members, and assigns, of and from any and all claims, demands, debts, contracts, expenses, causes of action, lawsuits, damages and liabilities, of every kind and nature, whether known or unknown, in law or equity, that I ever had or may have, arising from or in any way related to the services being provided to me by the Spa provided that this waiver of liability does not apply to any acts of gross negligence, or intentional, willful or wanton misconduct. Said services may include, but are not limited to, massage, pedicures, manicures, body treatments, hair removal, facials, hair coloring, texture changes, permanents, as well as hair cutting.

By this Waiver, I assume any risk, and take full responsibility and waive any claims of personal injury, death or damage to personal property associated with or unsatisfactory results from the said services being provided to me.

This Waiver and Release contains the entire agreement between the Spa and myself, and supersedes any prior written or oral agreements concerning the subject matter of this Waiver and Release. The provisions of this Waiver and Release may be waived, altered, amended or repealed, in whole or in part, only upon the prior written consent of the Spa and myself.

The provision of this Waiver and Release will continue in full force and effect even after the termination of the services being provided to me, whether by agreement, by operation of law, or otherwise.

I have read, understand and fully agree to the terms of this Waiver and Release. I understand and confirm that by signing this Waiver and Release, I have given up considerable future legal rights. I have signed this Agreement freely, voluntarily, under no duress or threat of duress, without inducement, promise or guarantee being communicated to me. My signature is proof of my intention to execute a complete and unconditional Waiver and Release of all liability to the full extent of the law.

Signature \_\_\_\_\_ Date \_\_\_\_\_