BODY & MIND

mobile day spa

WHERE YOU ARE TREATED LIKE ONE OF A KIND

Name _____ Date of Birth _____

Address _____ _____

City _____ State _____ Postcode _____

Telephone ( ) _____ Email _____

How did you hear about us? _____

HEALTH HISTORY (check all that apply)

□ Accident or Trauma
□ Allergies (list below)
□ Anxiety or Nervousness
□ Arthritis
□ Asthma
□ Athlete's Foot
□ Back Pain
□ Blood Clots
□ Bronchitis
□ Bruise Easily
□ Cancer
□ Carpal Tunnel Syndrome
□ Chronic Fatigue
□ Constipation
□ Contact Lens User
□ Depression
□ Diabetes
□ Diverticulitis
□ Dizziness
□ Edema
□ Emphysema
□ Fibromyalgia
□ Gastric Reflux
□ Headaches or Migraines
□ Heart Conditions
□ Hearing Impaired
□ Hepatitis
□ Hernia
□ High/Low Blood Pressure
□ HIV/AIDS
□ Infectious Diseases
□ Insomnia
□ Irritable Bowel Syndrome
□ Kidney Disease
□ Menstrual Pain
□ Muscular Disorders
□ Neck Pain
□ Nerve Disorders
□ Osteoporosis
□ Pacemaker or Metal Implants
□ Paralysis
□ Phlebitis
□ PMS
□ Pregnant
□ Rashes/Skin Conditions
□ Ruptured Discs
□ Sciatica
□ Seizures
□ Sinus Problems
□ Skin Cancer
□ Smoker
□ Spinal Disorders
□ Sprains or Strains
□ Stress (Stress Level 1-10) ____
□ Tendinitis
□ Thyroid Disorder
□ TMJ Disorder
□ Ulcers
□ Varicose Veins
□ Other

Allergies _____ ___

List other medical conditions not listed above _____

List any prescriptions, OTC medications and supplements you are currently taking _____ _____

Are you currently under a physician's care? □ Yes □ No

Do you exercise? □ Yes □ No

If yes, how many days a week? □ 1-2 □ 3-5 □ 6-7

Additional Notes:

Today's primary concern? _____

What is the primary purpose of your visit?

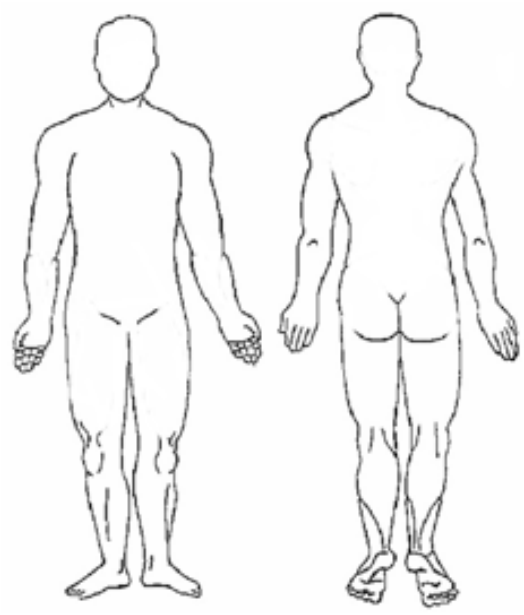
□ Pain relief □ Relaxation □ Therapeutic

When was your last massage and what type of therapy did you receive?_____

How often do you receive massage? □ Never □ Seldom □ Regularly

What level of pressure do you prefer? □ Light □ Medium □ Deep

Mark an **"X"** on the areas you feel pain and tenderness



Additional Notes:

I understand that the session should not be construed as a substitute for medical examination, diagnosis, or medical treatment. I understand that Body and Mind Mobile Day Spa is not qualified to perform, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such.

Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and answered all questions honestly. I agree to keep Body and Mind Mobile Day Spa updated as to any changes in my medical profile and understand that there shall be no liability on their part should I fail to do so.

I understand that no sexual activity, comment, or innuendo will be tolerated. This facility reserves the right to refuse services at their discretion based upon the client's conditions, therapist's skill set, client attitude or action, etc., without explanation or prior notice, and I agree to this policy.

I also understand that Body and Mind Mobile Day Spa reserves the right to refuse to perform treatments on anyone whom they deem to have a condition for which treatments are contraindicated. Since multiple treatments may be required, this medical form and all consents signed continue for all subsequent treatments by Body and Mind Mobile Day Spa regardless of the time between treatments.

Client Signature _____ Date _____

SKIN CARE

What is your skin type?

□ Normal □ Dry □ Combination □ Oily

What are you currently using on your skin?

□ Cleanser □ Mask □ Serums □ Other
□ Exfoliant □ Treatment □ Day Moisturizer □ Sunscreen
□ Toner □ Eye Cream □ Night Moisturizer □ Makeup

Are you using any of the following?

□ Accutane □ Retin A/Retinol/Vitamin A □ Birth Control: _____
□ AHA's/BHA's *(Glycolic, Lactic, Salicylic)* □ Vitamin C Products □ Other Topical Medications: _____

What are your primary skin concerns?

□ Acne and/or Acne Scars
□ Blackheads
□ Dark Circles
□ Dry or Flaky Skin
□ Hyperpigmentation (brown spots from sun, scars, hormonal)
□ Hypopigmentation (white spots)
□ Lack of Elasticity and Firmness
□ Rosacea
□ Sun Damage
□ Uneven Tone and Texture
□ Visible Capillaries
□ Whiteheads
□ Wrinkles and/or Fine Lines
□ Other _____

Have you recently had?

□ Botox/Dermal Fillers □ Laser Procedures □ Sunburn or Excess Sun Exposure
□ Chemical Peel □ Microdermabrasion □ Tanning Bed Exposure
□ Facial □ Permanent Makeup □ Waxing or Laser Hair Removal
□ IPL/Photofacial □ Plastic Surgery □ Other: _____

How often do you receive facials? □ Never □ Seldom □ Regularly
Do you have a tendency towards redness, rashes or hives? □ Yes □ No
Are you susceptible to Cold Sores or Sun Blisters? □ Yes □ No
Any past product reactions? Explain: _____
_____
_____

Additional Notes: