OASIS SALON AND SPA CLIENT PROFILE

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____ BIRTHDATE: ____/____/_____

HOW DID YOU HEAR ABOUT US? _____

1 Within the last year, have you been under a dermatologist's or physician's care? Yes_____ No_____
If yes, please specify _____
2 Have you had any health problems in the past or present? Yes_____ No_____
If yes, please specify _____
3 List any medications, supplements, vitamins, diuretics, isotretinoin, etc. that you take regularly.
_____
4 Do you smoke? Yes_____ No_____ Do you exercise regularly? Yes_____ No_____
5 Do you follow a restricted diet? Yes_____ No_____ Wear contact lenses? Yes_____ No_____
6 Do you have metal implants, pacemaker, piercings, hearing aids or dentures? Yes_____ No_____
If yes please specify _____
7 Do you have allergies? Latex, nickel, etc. Yes_____ No_____ Specify_____
8 Have you ever had an allergic reaction to Aspirin? Yes_____ No_____
9 Do you drink more than 4 caffeinated beverages daily (coffee, tea, soda)? Yes_____ No_____
10 Have you ever experienced claustrophobia? Yes_____ No_____
11 Rate your stress level on a scale of 1 to 5 (1=low stress, 5=high stress) _____
12 Are you currently affected by any of the following conditions? Please circle all that apply.

Arthritis Back pain Bruise easily Cancer Cardiac problems Circulatory problems

Contagious disease Diabetes Distended capillaries Edema Epilepsy Headaches

Hemophilia Hepatitis Herpes High blood pressure HIV positive Joint swelling

Neck pain Numbness Osteoporosis Phlebitis Rash Recent scar tissue Seizures

Soreness Stabbing pain Sunburn Swelling Tension Varicose veins

SKIN AND WAXING CLIENTS ONLY (QUESTIONS 13 – 24)

13 What are your specific concerns with your skin? _____
14 What skin care products are you currently using? Please circle all that apply.
Face: soap cleanser toner moisturizer masque exfoliator eye product serums
Body: soap shower gel scrubs oil body moisturizer depilatory products self tanners
15 Have you had a chemical peel, microdermabrasion, laser or light therapy, an injectable, or other cosmetic procedure in the last month? Yes_____ No_____
16 Have you waxed within the last 72 hours? Yes_____ No_____
17 Do you use Retin-A, Renova, Adaplene, or any other prescription skin products? Yes_____ No_____
18 Are you currently using any products that contain the following ingredients? Circle all that apply.
glycolic acid lactic acid exfoliating scrubs hydroxy acid vitamin A (i.e. Retinol)
19 Have you taken isotretinoin (accutane) within the last 12 months? Yes_____ No____

20 Do you ever experience any of these conditions? Please circle all that apply.
flakiness tightness dryness burning itching stinging redness sinus problems breakouts
21 What SPF sunscreen do you use on your face? _____ body? _____
22 Do you burn easily in the sun? Yes____ No____ Exposure to sun in last 48hours? Yes____ No____
23 Are you prone to cold sores or fever blisters? Yes_____ No_____ Presently? Yes____ No____
24 Do you sunbathe or use tanning beds? Yes_____ No_____

MASSAGE CLIENTS ONLY (QUESTION 25 - 30)

25 Have you ever experienced a professional massage or body work session? Yes_____ No_____
If yes, how recent? _____
26 Have you had any broken bones in the past two years? Yes_____ No_____
If yes, please specify _____
27 Have you had surgery? Yes_____ No_____
If yes, please specify_____
28 Have you been in an accident or suffered injuries in the past two years? Yes_____ No_____
If yes, please specify_____
29 Are you sensitive to touch or pressure in any area? Yes_____ No_____
If yes, please specify_____
30 Do you have any other medical conditions that I should be aware of? Yes_____ No_____
If yes, please specify_____

FEMALE CLIENTS ONLY (QUESTIONS 31 – 34)

31 Are you taking oral contraception? Yes_____ No_____
32 Are you pregnant or trying to become pregnant? Yes_____ No_____
33 Are you lactating? Yes_____ No_____
34 Are you currently having or within a 3 day pre or post menstrual cycle? Yes_____ No_____

We reserve the right to refrain from providing any skin or body treatment until written permission is given by your medical professional. It is my choice to receive any treatment. I understand that the information given is strictly confidential and will be used for no other purpose than to assist the Therapist in providing a suitable treatment which would take into consideration my specific requirements. I also understand that failure to disclose information could affect the results or cause an injury/illness and hereby release Oasis Salon and Spa and its staff from any claims resulting from such. Any information provided to me by the Therapist is for general education purposes only and is not intended for any medical of therapeutic purpose. All information is required by the State regulatory agency and Oasis Salon and Spa.

Client Signature: _____ Date: ___/___/_____

Future Updates:

Client Signature:_____ Date: ___/___/_____

Client Signature:_____ Date: ___/___/_____