Tranquil Oasis Client Intake Form

Name_______________________ Best Contact Phone ___________

Email _______________________ Birthdate___________

Address _______________________ City___________

State ________ Zipcode ___________ Anniversary Date ___________

Spouse Name ______________ Spouse's Cell Number ______________

How did you hear about me? _______________________

1. Do you have any health concerns? _____ Please list _______________________

____

2. What medications/supplements do you take regularly? _______________________

____

3. Do you have any skin issues? _____ Please list _______________________

____

4. Have you ever had any cold sores? ______ When was the last occurrence? ___________

5. Please list any & all allergies that you have. _______________________

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6. Do you wear contact lenses? __________ Wearing them now? __________

7. How much water do you drink a day? _______________________

8. Please Rate your stress level on a scale of 1 to 5 (1 being lowest) ______________

9. In your spa treatments, do you prefer: Total silence ____ Friendly chatter____ Mixture ______

10. On a scale of 1 to 5 (1 being low), please rate your pain tolerance. ______________

11. Have you ever experienced claustrophobia? _______Situation ______________

12. Are you pregnant or trying to become pregnant? Yes No

13. Are you on your menstrual cycle? Yes No

14. Do you experience ingrown hairs? Yes No

15. Have you ever been on Accutane? Yes No When? ______________

16. Have you ever had a chemical peel or microdermabrasion? Yes No Type? __________

17. What skin care products do you use for home care? ______________________________

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18. Do you use any prescription skin care products? Please list ______________________

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19. Do you consider yourself to be sensitive to the sun? Yes No

20. Circle the skin conditions/concerns you experience: Dry Tight Acne Rosacea

Pigmentation (sunspots) wrinkles fine lines Broken Capillaries

21. Do you have any permanent makeup? Yes No

22. Do you have eyelash extensions? Yes No

23. Do you wax? Yes No What areas? ______________________________

24. Do you get Botox or Fillers? Yes No When? ______________________________

If in the past 6 months, where? ______________________________

25. Have you had any laser treatments in the past 6 months? Yes No

26. What would you like to achieve through your spa experiences? ______________________

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27. Do you have? (circle all that apply) Diabetes High Blood Pressure

Keloids (raised scars) Epilepsy Metal Implants Skin Disorder

28. Anything else you think I should know? ______________________________

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I confirm that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. I release Tranquil Oasis Spa and Jaymie Martinez from any liability and assume full responsibility from the services I voluntarily receive. I have reviewed my consultation and that is evident by my signature below.

Client Signature ______________________________

Date ______________________________

Esthetician Signature ______________________________