jacqueline morgan day spa

# Confidential Consultation Form
**Please Print**

NAME _____
BIRTHDAY_____ADDRESS_____
CITY _____ (STATE) _____ZIP_____
CELL PHONE _____*Cell phone carrier (for free text message confirmations):* _____

EMAIL ADDRESS_____
***Would you like to be enrolled in the wellness rewards program?*** *It's Free! Earn 1% Back of Every Purchase in Wellness Rewards Points! Points can be used to purchase spa treatments, products or gift cards! Receive Monthly E-News & Spa Specials* **Yes!** **No Thanks**

What Brings you in Today?_____

How did you find out about us? _____

1. Do you have any allergies (cosmetic ingredients, food, medicines, latex, etc)?
O No O Yes (please specify) _____

2. Are you currently taking or using any medications, herbs, vitamins or retinols?
O Internal: _____
O Topical: _____

3. Are you undergoing chemotherapy or radiation therapy?
O No O Yes (please specify) _____

4. Do you have any body implants?
O Prosthesis O Metal O Other, please explain _____

5. Have you had any medical or surgical procedures in the past two years?
If yes, please explain_____
_____

6. Have you ever been diagnosed with any of the following?
O Anxiety O Depression O Cancer O Epilepsy
O Herpes O Hepatitis O Hemophilia O HIV
O Migraines O Thyroid (Hyper/Hypo) O Diabetes O Asthma
O High Blood Pressure O Low Blood Pressure O Heart Condition
O Mycosis (Fungal Infection) O Contact Dermatitis O Eczema
O Psoriasis O Seborrhea O Other_____

7. List any areas of acute (present) injury (breaks, sprains, bruising, swelling, etc)

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I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapists updated as to any changes in my medical profile and understand there will be no liability on the therapists part shall I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the treatment, and I will be liable for payment of the scheduled treatment.
Client Signature:_____Date:_____