Sundara Inn & Spa

Guest Heath Intake Form

Personal Information:

Name______________________________

Phone (Home)______________ Phone (Cell) ______________

Address______________________________

City/State/Zip______________________________

Email______________________ Date of Birth__________

Occupation______________________________

Emergency Contact________________ Phone__________

Date of Initial Visit______________________________

Medical History
The following information will be used to help plan safe and effective sessions.
Please answer the questions to the best of your knowledge.

1. Are you currently under medical supervision? Yes No
   If yes, please explain______________________________

2. Are you currently taking any medication or using any medicated ointment, (such as Accutane or Retinol? Yes No
   If yes, please list______________________________
____
____

3. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) phlebitis
( ) open sores or wounds
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) easy bruising
( ) recent accident or injury
( ) osteoporosis
( ) recent fracture
( ) epilepsy
( ) recent surgery
( ) headaches/migraines
( ) artificial joint
( ) cancer/chemo/radiation
( ) sprains/strains
( ) diabetes
( ) fever/infections
( ) decreased sensation/numbness
( ) swollen glands
( ) back/neck problems
( ) allergies/sensitivity
( ) Fibromyalgia
( ) heart condition
( ) TMJ
( ) high or low blood pressure
( ) carpal tunnel syndrome
( ) circulatory disorder
( ) tennis elbow
( ) varicose veins
( ) atherosclerosis
( ) pregnancy If yes, how far? __________
( ) claustrophobia
( ) high blood pressure
( ) lymphatic illness
( ) asthma
( ) stress
( ) depression
( ) cold sores
( ) nail fungus/nail discoloration
( ) warts on feet

Please explain any condition that you may have marked above______________
____
____
____
____

4. Is there anything else about your health history that you think would be useful for your therapist to know to plan a safe and effective treatment for you?
____
____
____

If receiving a massage, body treatment, or facial, please complete.

1. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain______________________________
2. Do you have any allergies to latex, Lactic acid, Salicylic acid, or nuts? Yes No
   If yes, please explain______________________________
3. Do you have sensitive skin? Yes No
4. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( )?
5. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please explain______________________________
6. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please explain______________________________
7. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, how do you think it has affect your health? muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other______________________
8. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If receiving a massage, please complete.

1. Have you had a professional massage before? Yes No If yes, how often do you receive massage therapy? ____
2. Do you see a chiropractor? Yes No If yes, how often? ________________
3. Do you have any difficulty lying on your front, back, or sides? Yes No
   If yes, please explain____
4. Do you have any particular goals in mind for this massage session? Yes No
   If yes, please explain____

Circle any specific areas you would like the massage therapist to concentrate on during the session:

( ) Head	( ) Neck	( ) Shoulders	( ) Upper arms
( ) Forearms	( ) Hands	( ) Upper back	( ) Lower back
( ) Hips	( ) Thighs	( ) Lower Legs	( ) Feet

If receiving an Age Defying Lift or Ultra Red Carpet Facial, please complete.

Are you pregnant? Yes No
Do you have any metal implants in the head or neck? Yes No
Do you have any silicone implants in the head or neck? Yes No
Do you have a pacemaker? Yes No
Do you have epilepsy? Yes No
Have you undergone any cancer treatments in the last 5 years? Yes No
Do you have Thrombosis or Phlebitis? Yes No
Do you have any heart or muscular conditions? Yes No
Have you used Retin A in the last 4 weeks? Yes No
Have you used Accutane in the last 6 months? Yes No
Have you had any collagen or injectable filler in the last 2 months? Yes No
Have you had Botox in the last 4 weeks? Yes No

If receiving a Waxing Treatment, please complete.

Wax Temp:_________ (Range should be between 150°-160° —Staff use only)
Are you currently being treated for any type of cancer? ______________________
Are you currently being treated for diabetes? ___________________________
Have you used any Glycolic or Alpha Hydroxy Acids in the past 72 hours? _______
Are you currently using Retin A products? _______________________________
Have you recently received a chemical peel? _____________________________
Have you used Accutane in the past 6 months? ____________________________
Have you used Renova recently? _____________________________________
Are you exposed to the sun on a daily basis? ______________________________
Do you work near a UV source? ______________________________________
Do you regularly use tanning beds? ___________________________________
Are you currently taking any medications, being treated by a dermatologist or plastic surgeon for any conditions or surgery? ________Please explain? ______________
____
Start of last menstrual cycle:
____
(Be aware that your skin will be extra sensitive during this time.)

I, ____ (print name) understand that the treatment I receive is provided for the basic purpose of relaxation and stress relief. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that treatment should not be construed as a substitute for medical examination, or diagnosis, and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that the therapists are not qualified to perform spinal or skeletal adjustments, 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 treatment should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Guest____
Date ___________________________

Signature of Therapist____
Date____________________________

Signature of Therapist____
Date____________________________

Signature of Therapist____
Date____________________________