



Sundara Inn & Spa

Guest Health Intake Form

Personal Information:

Name _____
Address _____
Phone Number _____ Date of Birth _____
Emergency Contact _____ Occupation _____

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.

- Are you currently under medical supervision? Yes No
If yes, please explain _____
- Are you currently taking any medication or using any medicated ointment, (such as Accutane or Retinol?) Yes No
If yes, please list _____
- Please check any condition listed below that applies to you:

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

Please explain any condition that you may have marked above _____

- Is there anything else about you 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, please complete.

- Have you ever had a professional massage before? Yes No If yes, how often do you receive massage therapy? _____
- Do you have any difficulty lying on your front, back, or sides? Yes No
If yes, please explain _____

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

Have you ever had a professional facial before?

1. Do you have any allergies? Yes No

If yes, please explain _____

If receiving a HydraFacial, please complete.

Are you pregnant? Yes No

Do you have epilepsy? Yes No

Have you undergone any cancer treatments in the last 5 years? Yes No

Have you used Retin A in the last 4 weeks? Yes No

Have you used Accutane in the last 7-10 days? Yes No

Have you used any collagen or injectable filler? Yes No

Have you had Botox in the last 5-7 days? Yes No

Do you have any autoimmune diseases? Yes No

Have you had any recent laser treatments? Yes No

Have you had any recent waxings? Yes No

Have you had a peel in the last 30 days? Yes No

Do you have any skin conditions? Yes No

If yes please explain _____

If receiving a Waxing Treatment, please complete.

Are you currently being treated for diabetes? Yes No

Have you used Glycolic or Alpha Hydroxy Acids in the past 72 hours? Yes No

Are you currently using Retin A products? Yes No

Have you recently received a chemical peel? Yes No

Have you used Accutane in the past 6 months? Yes No

Have you used Renova recently? Yes No

Are you exposed to the sun on a daily basis? Yes No

Do you work near a UV source? Yes No

Do you regularly use tanning beds? Yes No

Are you currently taking any medications, being treated by a dermatologist or plastic surgeon for any conditions or surgery?__ Yes No

If yes, please explain _____

Are you currently be treated for any type of cancer? Yes No

If yes, please explain _____

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 constructed 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 to 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 _____

