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.

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
( ) 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	( ) heart condition
( ) back/neck problems	( ) allergies/sensitivity	( ) Fibromyalgia
( ) TMJ Disorder	( ) high or low blood pressure	( ) high blood pressure
( ) carpal tunnel syndrome	( ) circulatory disorder	( ) warts on feet
( ) tennis elbow	( ) varicose veins	( ) asthma
( ) atherosclerosis	( ) claustrophobia	( ) lymphatic illness
( ) depression	( ) cold sores/herpes	( ) nail fungus/nail discoloration
( ) sensitive skin	( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis	

( ) pregnancy If yes, how far?_____

Please explain any condition that you may have marked above_____

_____

_____

4. 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.

1. Have you ever had a professional massage before? Yes No If yes, how often do you receive massage therapy?_____
2. 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:

_____

_____

_____

( ) hips/glutes initials_____

Have you ever had a professional facial before? Yes No

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_____