Raintree wellness spa

Guest Intake Form

Date: _____/_____/_____
dd mm yyyy

Please complete the following profile information so that we may correctly evaluate your needs for skin care, body treatments and home maintenance. This information is completely confidential and to be used only for this analysis.

General Information

Male ☐ Female ☐ Shoe Size _____ (for Raintree footwear issued for facial and body treatments)

Last Name: _____ First Name: _____

Address: _____ City/Prov: _____

E-mail: _____(used for sending birthday gifts and monthly e-news only. Your information is never rented or sold.)

Home phone #: (_____)_____ Cell Phone #: ____)_____

Profession: _____ Date of birth: _____/_____/_____
dd mm yyyy

How did you hear about our spa?

Publicity/Event ☐ Referral ☐ Referred by:_____

Gift Certificate ☐ Newspaper ☐ Other ☐ (please specify):_____

When was your last visit to a spa? Within 4 weeks ☐ 1-6 mos ☐ 6 mos+ ☐ First Time ☐

Face Care & Waxing Information

Please check the following items/conditions that are applicable:

Regime/Products Used		Sensitivities	
Cleansing gel/milk	☐	Tendency to burn easily	☐
Toning lotion	☐	Using Accutane, Retin A or other prescription products	☐
Gommage/Exfoliant	☐	Have had a reaction to skin care products in the past	☐
Serum	☐	Have had laser, chemical peels or Microdermabrasion	☐
Day cream	☐	Wear contact lenses	☐
Night cream	☐	Tendency to redness	☐
Mask	☐	Tendency to itchiness/dryness/peeling/burning sensations	☐
Eye/lip cream	☐	Tendency to oiliness	☐
Sunscreen	☐	Tendency to breakouts or ingrowns	☐
		Tendency to cold hands and feet	☐

Please specify any unusual skin conditions:_____

How much plain water do you consume daily? None ☐ 1-4 glasses ☐ Over 4 glasses ☐

Do you visit (or are you planning to visit) a tanning salon on a regular basis? Yes ☐ No ☐

Which skin care brand(s) do you usually use?_____

Over ➲

Health Information

Cardiovascular

Heart problem (pacemaker) ☐
Vascular disorder ☐
Low blood pressure ☐
High blood pressure ☐
Circulatory problem ☐

Respiratory

Respiratory/asthma problems ☐
Smoker ☐

Digestion/Elimination

Diabetes ☐
Constipation ☐
Liver/Gall bladder ☐
Kidney/Urinary problem ☐
Digestive problem ☐

Head/Neck

Sinus Problems ☐
Headaches/Migraines ☐
Epilepsy ☐

Muscel/Joint

Automobile accident ☐
Arthritis ☐
Fractures/Dislocation ☐
Fibromyalgia ☐
Metallic implants ☐
Osteoporosis ☐

Other

Pregnant or possibility of ☐
Menopause/Pre Menopause ☐
Hormonal Changes ☐
Thyroid Condition ☐ Hypo ☐ Hyper ☐
Numbness ☐
Cancer ☐
Psoriasis ☐
Claustrophobia ☐
Infectious condition (TB, HIV, Hepatitis) ☐

Preferred Massage Pressure Firm ☐ Med. ☐ Light ☐

Recent Surgeries (within last two years)

Date: _____ Type:_____
Date: _____ Type:_____

Allergies

_____
_____

Medications/Supplements

_____
_____
Known side effects: _____
_____

Please specify any sore regions of your face or body:
_____

Are you undergoing regular treatments or seen regularly by a:

dermatologist ☐ chiropractor ☐ osteopath ☐ physiotherapist ☐

If so, please specify the purpose: _____

I confirm to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

_____ _____
Guest signature **Date (dd/mm/yyyy)**

Health Review – Subsequent Raintree Visits

Has there been any change in your health history since your last visit (i.e. medications, illness, surgery, allergies, muscular problems, etc.)?

NO	YES	DETAILS	GUEST'S INITIALS	DATE (dd/mm/yyyy)
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			