First: _____ Middle:_____ Last:_____ Date:_____

Street: _____ City: _____State: ____Zip:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____ Age: ____

Occupation: _____ Primary Care Physician: _____

Anniversary (If married):_____Shoe Size: _____

Email: _____ *(Your email is kept confidential. It is only used to send monthly E-Newsletter with discounts , upcoming events , and special promotions at Still Waters)*

Emergency Contact's Name and Phone Number: _____

How did you hear about us? TV/ Radio/ Internet/ Newspaper Other: _____

If a client referred you, please tell us who so we may send them a special reward!! (This does not apply to gift certificate purchases or redemptions) **Client's Name: _____**

Allergies to Medications? _____ Current Medications _____
Other Allergies? _____

Health History

Please check if you have any of the following:

Skin

___ Athlete's Foot _____

___ Skin/Toe Nail Fungus_____

___ Rashes_____

___ Warts_____

___Boil/Abscesses_____

___Eczema_____

___Bruise easily/Keloid_____

___Skin Cancers_____

Nervous System

___ Pinched Nerves_____

___Herpes/Shingles_____

___Numbness/Tingling_____

___Sciatica_____

___ MS_____

___Anxiety_____

Other

___Cancer/Tumors_____

___Diabetes_____

___Hepatitis A, B, C_____

___Auto Immune Disorders_____

___HIV/AIDS_____

Musculo-Skeletal

___Disc Injuries/Spinal Problems___

___Bone Joint Disease/Injury_____

___Arthritis_____

___Osteoporosis_____

___Fibromyalgia_____

___Muscular Pain/Joint Pain_____

___Headaches_____

___TMJ_____

Circulatory

___Cardiovascular_____

___Hyper/Hypo-tension_____

___Blood Clots_____

___Varicose Veins/Spider Veins____

___Seizures/Epilepsy_____

___Circulation Problems_____

___Pacemaker_____

___Asthma_____

Are you Pregnant? **YES NO** Expected Date: __/__/__ Are you nursing? **YES NO**

Has your physician deemed this pregnancy high risk? **YES NO**

Which of the following concerns you about your body? Please circle all that apply.

Sun Damaged Skin Brown Spots Dry Skin Cellulite Leg Veins

Unwanted Hair Wrinkles Rosacea Thin Lips Smile Lines

Muscular Discomfort Unwanted Fat Hyperhydrosis Acne

Have you had any of the following? : (Please Circle)

Chemical Peel Laser Treatments Botox Filler Microderm

Skin Type

Do you use Retnoids? (Retin A, Tazovac, Differin, Retenal, Etc)

Have you ever been on Accutane? YES NO if so when? _____

Do you have any tattoos or permanent makeup? _____

When have you last tanned your skin? (Sun or Tanning Bed)_____ **Self Tanned? _____**

Check if you are interested in any of the following:

__Botox __ Laser Hair Removal __ Chemical Peels __ Liposonix Fat Reduction
__ Fillers __ Skin Tightening __ Velashape __Dermplaning __Permanent Makeup
__Micro Needling __IPL __Laser Vein Removal __Skin Tag Removal __Hydrafacial

For Massage

What is your preferred pressure? (Your therapist will also discuss this with you)

_____Light _____ Medium ____Firm ____ Very Firm/ Myofascial

The spa reserves the right to recommend that you reschedule a treatment or even refuse service at the technician's discretion if you have certain conditions, including intoxication that are contraindicated for skin and body services. Still Water's employees have the right to refuse and or stop a treatment if the clients conduct themselves inappropriately in our place of business. I also herby authorize Still Waters' employees to have full access to my client files for the purpose of accessing and performing the most effective and proper services for me.

Signature_____ Date_____