THE SPA ON GREEN STREET

: Name _____

CONFIDENTIAL HEALTH HISTORY

(**If female**) Are you pregnant? ❒ Yes ❒ No
If yes, which trimester? _____

Are you currently undergoing treatment for any health condition that would have bearing on your spa treatment?
❒ Yes ❒ No If yes, have you checked with your doctor about receiving spa treatments? ❒ Yes ❒ No

Are you currently taking any prescriptions or medications that would have bearing on your spa treatment? ❒ Yes
❒ No If yes, have you checked with your doctor about receiving spa treatments? ❒ Yes ❒ No

List any past surgeries, broken bones, major car accidents and injuries: _____
_____

List any known allergies: _____

Do you see a dermatologist? ❒ Yes ❒ No If yes, please explain:
_____

Check any areas that apply:

❒Blood clots	❒AIDS	❒Epilepsy	❒Eczema or Psoriasis
❒Poor Circulation	❒Heart Attack	❒Arthritis	❒Cancer/ skin abnormalities
❒Heart Palpitation	❒Pinched Nerves	❒Chest Pains	❒Fibromyalgia
❒TMJ Dysfunction	❒Asthma	❒Neck Pain	❒Contagious Disease
❒Cold sores/Herpes	❒Swollen Joints	❒Scoliosis	❒Skin Irritations
❒Blood Pressure High	❒Type 1 Diabetes	❒Type 2 Diabetes	

Please list any additional health concerns:
_____

MASSAGE

Please check the areas of the body you would like the therapist to emphasize:

❒Full Body ❒Back ❒Neck ❒Arms ❒Hands ❒Legs ❒Feet ❒Other:_____

FACIAL

Please check any of the following conditions you are experiencing with your skin:

❒ Flaky	❒ Dryness	❒ Oily	❒ Breakouts
❒ Sun Damage	❒ Discoloration	❒ Clogged pores	❒ Fine Lines

Any other concerns? If so, please describe:
_____