
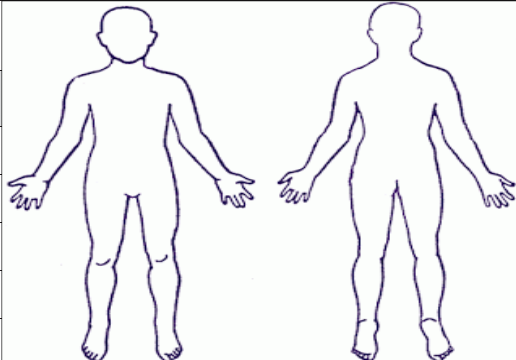


Name:	Date:	Occupation:
Address:	Phone:	Date of Birth:
City:	Prov:	Postal Code:
Your Aromatherapy Retreat Preference: (Please Circle Below in Spa)		Phone:
		
NONE		
General Health		
1. Rate your level of stress: (5 = highest, 1= Lowest) 1. 2. 3. 4. 5.		
2. Do you have any metal implants, a pacemaker or body piercings?		
3. Do you wear contact lenses? Yes No		
4. Please list any accidents or surgeries:		
5. Please list all Allergies :		
6. List the medications you are currently taking:		PLEASE SHADE ABOVE AREAS OF CONCERN
Massage Services		Goal For your massage session
Have you ever had a professional massage before?		<input type="checkbox"/> Relaxation <input type="checkbox"/> Pain Relief
What type of pressure do you prefer? <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Firm		<input type="checkbox"/> Stress reduction <input type="checkbox"/> Specific area of concern
Health History		
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Lymph Edema	<input type="checkbox"/> Herpes/Shingles
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Eczema
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Varicose Veins	
<input type="checkbox"/> Rashes	<input type="checkbox"/> Jaw /TMJ	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Constipation	<input type="checkbox"/> Sprains/Strains	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gas/Bloating	<input type="checkbox"/> Headache
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Spasms/Cramps	
<input type="checkbox"/> Fracture/Break	<input type="checkbox"/> Pregnancy (weeks)	<input type="checkbox"/> Fatigue/Sleep Disorder
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Tanning in past 24hrs	
<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Cancer ,Type:
		<input type="checkbox"/> Iodine/Shellfish Allergy
Skin Care		
1. Are you under the care of a dermatologist Yes No		
2. Do you use: <input type="checkbox"/> Accutane <input type="checkbox"/> Renova <input type="checkbox"/> Adapalene <input type="checkbox"/> Other prescription skin products		
3. Have you had: <input type="checkbox"/> Chemical peel <input type="checkbox"/> Botox/Rejuvaderm <input type="checkbox"/> Fillers <input type="checkbox"/> Resurfacing treatments		
4. Are you currently using any products that contain: <input type="checkbox"/> Glycolic Acid <input type="checkbox"/> Lactic Acid <input type="checkbox"/> Vitamin A		
5. Do you have any skin sensitivities or irritants?		
Skin Maintenance		
Products You Use: <input type="checkbox"/> Soap <input type="checkbox"/> Cleanser <input type="checkbox"/> Toner <input type="checkbox"/> Moisturizer <input type="checkbox"/> Exfoliant <input type="checkbox"/> Mask		
Skin Type: <input type="checkbox"/> Oily/Congested <input type="checkbox"/> Dry/Dehydrated <input type="checkbox"/> Acne		

In consideration for receiving Healing Springs Spa services, I hereby release, waive, discharge, and covenant not to sue Healing Springs Spa, Harrison Hot Springs Resort and Spa or it's owners, officers, agents, servants, contractors or employees from any and all liability, claims, demands, actions, and causes of action related to any loss, damage, or injury that may be sustained by me or property belonging to me, whether caused by negligence or otherwise, while participating in such activity or while on the Harrison Hot Springs Resort and Spa premises. I am fully aware of the risks involved and hazards connected with spa treatment, and I voluntarily assume full responsibility for any risks of loss, property damage, or personal injury, that may be sustained by me, or any loss or damage to property owned by me as a result of being engaged in such an activity, whether caused by the negligence or otherwise.

SIGNATURE: _____

DATE: _____

I, _____, Legal guardian of _____
 Consent to the treatment of the above named dependent child.

SIGNATURE: _____

DATE: _____