EPIC
DAY SPA

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Email _____ DOB_____/_____/_____

How did you hear about Epic? _____

RELEASE OF LIABILITY

It is my choice to receive spa therapies. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update Epic Day Spa of any changes to my health status. I understand that Estheticians, Massage Therapists and Nail Techs do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal manipulations. I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and that is recommended I see a primary health care provider for that service. If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24 hour notice, I agree to pay the missed appointment fee that applies.

I understand that any illicit or sexually suggestive behavior, remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled service.

GUEST SIGNATURE _____ **DATE** _____

GENERAL INTAKE

The following information is necessary to evaluate and meet your individual needs for professional services and home care maintenance. All Information collected is strictly confidential.

Are you currently under any medical or chiropractic care? _____ If yes, please describe _____

_____

Do you have any past injuries / medical conditions or are you currently on any medications that we may need to be aware of before performing your service(s) today? _____

Please indicate if you have and/or have ever had any of the following medical conditions (please note if past condition)

- ☐ Allergies
- ☐ Asthma
- ☐ Claustrophobia
- ☐ Dislocated Joints
- ☐ Varicose Veins
- ☐ Cancer
- ☐ Arthritis
- ☐ Nail or skin infections
- ☐ Sinus problems
- ☐ Heart condition
- ☐ Edema
- ☐ Diabetes
- ☐ Contagious Disease
- ☐ Thyroid Disorder
- ☐ Other : _____
- ☐ Seizures
- ☐ Eczema
- ☐ Hemophilia/Bleeding
- ☐ Pregnancy / # of weeks: _____

MASSAGE INTAKE

Have you had a massage before?_____ If yes, when? _____

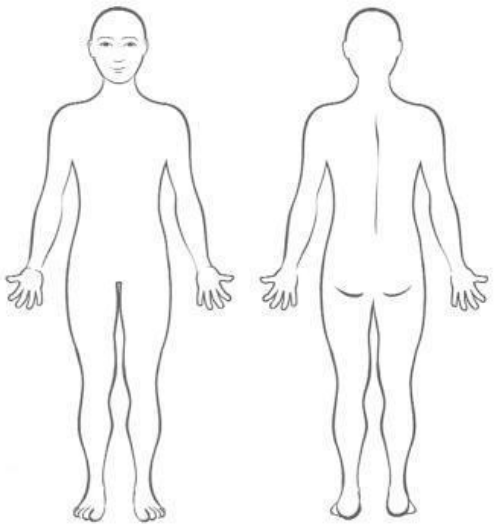
Tell us about your daily activities (running, desk job, lifting weights, etc):

_____

What type of pressure do you prefer? Please circle one below :

Relaxation (Light/Medium) OR Therapeutic (Medium to Heavy)

Please indicate on the diagram (right) any areas that you would like your therapist to pay special attention to



Are there any areas that are sensitive or painful to touch that you would like us to avoid? _____

Do you enjoy scalp massage? _____

Face Massage? _____

Would you like table width extenders or a breast support pillow? _____

Do you have any special requests? _____