SOLACE
BODY SOLUTIONS

Name_____ Phone_____ Date_____
Mailing Address_____ Email_____
D.O.B._____ Age____ Occupation_____Last Treatment_____
Place a check mark if you suffer from any of the following

___diabetes	___skin disease	___joint /muscle injuries
___migraines	___kidney disease	___areas of numbness
___joint diseases	___high blood pressure	___areas of chronic pain
___tension headaches	___infectious disease	___paralysis
___heart problems	___respiratory disease	___phlebitis

List allergies: _____
List any medications, including over the counter: _____
Are you pregnant? Date due, if so: _____
Do you have any communicable diseases? (HIV, Hep C, Herpes, etc) _____
Goals for your services today? _____
Recent injuries or treatments? _____
Have you ever had a reaction to treatments? If so, describe:_____
Is there anything else your technician should know, in order to provide better service? _____
Have you received any of the following? If so, please give date of last treatment.
Dermabrasion _____ Botox _____ Retin-A _____Accutane _____ Alpha Hydroxy _____
Tetracycline/Acne/ other skin medication _____
Last tanning experience, sun or tanning bed: _____
Describe your skin care regimen, including face and body products: _____
_____
Is your skin dry/ oily/ sensitive? _____

I have been advised that the service(s) provided to me by this salon could have unfavorable results including, but not limited to: allergic reaction, irritation, burning, redness, soreness, etc. I am aware that certain medications and over the-counter products can significantly increase the risk of injury when combined with skin care services. I understand that this salon does not recommend wax treatments for customers using Retin-A, Accutane products containing alpha hydroxy, or any other skin thinning treatments. I hereby confirm that I am not using any medication that may cause or contribute to any such injury/reaction, and I will advise my technician should I use any such medication in the future. After the treatment, I will not have any harsh substances or exfoliating products on my skin for a period of 72 hours. I understand that this is a cosmetic procedure and no medical claims are expressed or implied, and no outcome is guaranteed. I do not have a burn, rash, cut, or puncture on the treatment area. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or stroke may be adjusted to my level of comfort. I AM OF LAWFUL AGE (18) AND HAVE READ AND FULLY UNDERSTAND the contents of this document and represent myself as physically capable of using the services offered by this facility. I understand that there are often inherent risks associated with skin care and massage services, and I agree that as a condition of providing these services on an ongoing basis, I will not hold this salon/ technician liable.

Signed: _____ Date: _____
Printed Name: _____ Technician: _____