



La Vita Bella Day Spa Service Intake Form

Name _____ Phone (h) _____ (m) _____
Address _____
Email _____ Birthdate _____
How did you discover us? _____

General Questions

On a scale of 1 to 10, with 1 being LOW and 10 being HIGH, What is your CURRENT level of stress? _____
How many ounces of water do you drink daily? _____ Do you exercise? How often? _____
List current prescribed medications and purpose _____
Do you have any allergies: _____
List any major injuries, illnesses or surgeries within the last 3 years _____
Are you currently, or within the last 12 months, been under the care of a physician? If so, please explain: _____

Please mark any of the following that you now have or have had in the last year.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Lactating | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Shooting Pain / Numbness |
| <input type="checkbox"/> Blood Pressure Concerns | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Menstrual / Ovarian Problems | <input type="checkbox"/> Spinal Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tendonitis / Bursitis |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Headaches | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Jaw Pain ~ TMJ | <input type="checkbox"/> Pregnant? Due Date _____ | |

Massage History / Session Information

Have you ever received a professional massage? No Yes Date of last massage _____
What result do you want from your massage sessions? _____
What type of pressure do you prefer: _____

Facial History / Session Information

Have you ever received a professional facial? No Yes Date of last facial _____
When you go out into the sun, do you (circle): always burn usually burn sometimes burn rarely burn never burn
Do you use a daily sunblock? Yes _____ spf No, because _____
Do you use Retin A, Renova, Adapalene, or prescribed skin products? Yes No Products Used: _____
In the last month, have you had any chemical peels, microdermabrasions, or resurfacing treatments? Yes No
Are you using any products containing the following: Glycolic Acid Lactic Acid Exfoliating Scrubs
Do you have any (circle all that apply) contact lenses metal implants pacemaker body piercings
What concerns do you have regarding your skin? Please check all that apply whether on face or total body.
 Acne / Breakouts Dry Skin Pore Cleanse Wrinkles
 Crows Feet Moisturize Puffy Eyes Other _____
 Dark Circles Oily Skin Sagging Skin

Client Consent

I have completed this client in-take form to the best of my knowledge and that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. I also understand that La Vita Bella Day Spa LLC is not responsible for any problems that may occur during any treatment if I am using any topical or oral, prescribed or over the counter medications.

Signature: _____ Print Name: _____ Date: _____