



MASSAGE AND BODYWORKS

## Esthetic Wellness Intake Form

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

How did you hear about Origins Massage and Bodyworks?

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Please help ensure a safe and comfortable experience by providing the following information.  
(Please circle all that apply)

Headaches    Pregnant    Strokes    Neck Problems    Skin Infection/Disorder

TMJ Dysfunction/Jaw Pain    Other: \_\_\_\_\_

List current medications: \_\_\_\_\_

What are your skin care goals:

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What skin care products are you currently using?

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Have you had any chemical peels, micro-dermabrasion, or any resurfacing treatment?

Yes    No                      In the last month?                      Yes                      No

Do you use Accutane, Retin-A, topical vitamin A or other prescription skin products?

Yes    No                      In the last three months?                      Yes                      No

Have you used any of the following hair removal techniques in the past six weeks?

Shaving                      Waxing                      Electrolysis                      Sugaring                      Laser

Are you using products that contain the following ingredients?

Glycolic Acid    Lactic Acid    Exfoliating Scrubs    Any hydroxyl product    Vitamin A Derivatives

Please list any specific allergies: \_\_\_\_\_

Have you had a reaction to any of the following:

Plants    Herbs    Fruits    Sunscreens    Latex    Cosmetics    Pollen    AHA's

Do you burn easily in moderate sunlight?                      Yes                      No

Do you have a tendency to redness?                      Yes                      No

## Women Only:

Are you pregnant or trying to become pregnant?	Yes	No
Are you currently breastfeeding?	Yes	No
Are you taking oral contraceptives?	Yes	No
Are you undergoing any hormonal replacement therapy?	Yes	No

## Micro-Current Users:

The NuFace Trinity Device should not be used by minors, pregnant women, people subject to seizures, people with cancer/tumors, people with cardiac pacemakers, people with implanted defibrillators/stimulators, people with electronic implanted devices.

## **RELEASE AND WAIVER**

We hope that you will take full advantage of the services that we have to offer. By signing below, you acknowledge and agree to the following: (a) you understand that the use of our facilities, services, programs and premises includes an inherent risk of injury and assume all of the risks of using our facilities, services and programs; (b) you are in good physical condition and have no disabilities, diseases, illnesses, or other conditions that could prevent you for using our facilities without injury or impairing your health; and (c) any information you receive during or through any of our services, is just for information purposes only and is not intended to replace the advice of your Dermatologist.

I understand that the risk of injury includes, but is not limited to, injuries arising from or relating to the use by you or others of restrooms, treatment rooms, and activities, and other facilities; injuries arising from or relating to participation by you or others in supervised or unsupervised activities or programs through or at Origins Massage and Bodyworks; and accidental injuries occurring anywhere at Origins Massage and Bodyworks, including lobbies, walk-ways, restrooms and treatment rooms. If you have any special requirements or limitations, you agree to disclose them to us before using our facilities. By signing below, you waive all claims which you may have against Origins Massage and Bodyworks, and hereby release from all claims and covenant not to sue Origins Massage and Bodyworks their owners, lenders, investors, employees, agents, and officers arising out of or in any way connected with your use of our facilities, premises, equipment, services, or programs. You acknowledge that you have carefully read this and fully understand it is a release of Liability and Waiver of any right that you may have to bring a legal action to assert a claim against us for mere negligence.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contradictions and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and /or skin care professional from liability and assume full responsibility thereof.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_