RĒNU
DAY SPA

Renu Day Spa
INCLUSIVE HEALTH HISTORY

At Renu Day Spa, our philosophy is inclusive. We believe that by combining the best of topical skincare, internal nutrients and emotional self care we can help you achieve whole body health. Please take a moment to fill out the questionnaire below; your answer will allow your service provider to target your specific conditions to provide you with a truly personalized experience.

Name:_____Birth Date:_____

Contact in Case of Emergency (name and phone number):_____

Occupation/WorkPlace:_____

GENERAL HEALTH (check all that apply)

_____Heart Problems _____High/Low Blood Pressure _____Hormonal Problems

_____Diabetes _____Over/Under Active Thyroid _____Skin Cancer

_____Allergies (please list)_____

Are you currently under a physician's care?_____
List any medication _____
List any other health problems your therapist should know about_____

PLEASE INDICATE THE FOLLOWING:	**YES**	**NO**
Do you have any metal implants or a pacemaker?	____	____
Do you wear contact lenses?	____	____
Do you smoke?	____	____
Do you have sinus problems?	____	____
Have you recently had X-ray?	____	____
Recent injury?	____	____
Briefly explain the type of injury(ies) and when	____	____
Recent car accident?	____	____
Ever had a massage before?	____	____
Female Clients Only:		
Are you or are you trying to become pregnant?	____	____
Are you pre or post menstrual (3days)?	____	____

TOPICAL SKIN HISTORY

Have you recently had:

____Laser Surgery ____Sunburn or Excess Sun Exposure ____Chemical Peel

____Microdermabrasion ____Tanning Bed Exposure ____Waxing or Hair Removal

Other, please explain_____

Do you have a tendency towards redness, rashes or hives?_____

Are you using any of following:

____Retin A/Renova ____Vitamin C Products ____Other Topical Medications

____Alpha Hydroxy Products ____Accutane Explain_____

____Other_____

Which brands are you currently using on your skin?

Cleanser_____ Toner_____Treatment (AHA,Vitamin C, Other)_____

Day Moisturizer_____ Night Moisturizer_____ Eye Cream_____

Mask_____ Sunscreen_____ Other_____

Any past products reaction? Explain:_____

What are your primary skin concerns?_____

INTERNAL HEALTH

Are you currently taking any of the following?

____Birth Control Pills ____Vitamin Supplements. If yes, which ones_____

____Hormone Therapy _____

Do you feel that you have a balanced diet? If not, what would you like to change?_____

EMOTIONAL CARE

Are you under a lot of stress?_____ Rate Stress 1-10_____

Do you exercise regularly?_____ If yes, how many times a week?_____

In what areas of your body do you carry most of your tension and stress?_____

When was the last time you did something for yourself?_____

Is there anything about yourself that you would like to improve or change?

1._____

2._____

3._____

Do you participate in group activities?_____

How did you hear about our facility?_____