

Welcome to Bayshore Spa

Please take the time to fill out this questionnaire. This will help us serve you better!

Name _____ Address _____

City _____ State _____ Zip _____ E-mail _____

Home Phone (____) _____ Work (____) _____ D.O.B. _____

Type of Employment _____ Any Lifting Involved? Yes ___ No ___

Please circle any answers that apply:

1. How did you hear about our office? Fax, Newspaper, T.V., Coupon, or Referred by _____
2. Have you ever had massage or chiropractic care before? Yes No Did it help? Yes No
3. Are you presently being seen by a Health Care Professional? Yes No
please explain: _____
4. Do you presently have any of the following symptoms? (Please Circle all that apply)

NECK PAIN	SHOULDER PAIN	MIDBACK PAIN
LOWER BACK PAIN	RADIATING LEG PAIN	NAUSEA
NUMBNESS	TINGLING	LEG NUMBNESS
BLURRED VISION	RINGING OF EARS	HEADACHES
KNEE PAIN	HIP PAIN	ANKLE/FOOT PAIN
OTHER SYMPTOMS _____		
5. Are you currently taking any medications? Yes No , please list: _____
6. Have you been involved in a motor vehicle accident within one year? Yes No
7. Have you been involved or are you being treated for a work injury? Yes No
8. Do you feel stressed or sometimes overwhelmed? Yes No
9. *You deserve regular pampering and care.* Are you interested in joining our Massage Club? (Lower costs) Yes No
10. Do you have any other person you would like to contact for a massage?

Names	Phone
_____	(____) _____
_____	(____) _____
_____	(____) _____

Receive a complimentary ½ hour massage, by simply joining our Hands On Club today, ask your therapist for details.

BAYSHORE SPA MEMBER GUIDELINES

1. All memberships are based on a monthly debit or annual prepayment
2. All massages are to be used within 60days of the previous month's debit date. Those not used will be forfeited.
3. All memberships are non-transferable.
4. *Bayshore Spa* reserves the right to cancel client's membership at any time without cause
5. *Bayshore Spa* memberships are for symptom-free maintenance care and cannot be used for the treatment or symptoms resulting form an auto accident, Work injury, or any other acute injury.
6. All membership use is based on appointment and hours of operation of *Bayshore Spa*.
7. No cash or credit refunds for unused services.
8. Each massage is assigned to the appropriate technique and therapist. That means, we have the right to change your techniques and/or therapist.

*I have read the above stipulations of my membership and will abide by all **Bayshore Spa**. I am at least 18 yrs. Of age, and have no medical condition which would preclude me from service.*

By signing, you are authorizing massage treatment by a licensed massage therapist, it will not obligate you to join, however should you choose to join, you will follow the previous guidelines.

Signature of client

Date

Signature of parent (If less than 18 years of age)

Date

Same-day cancellations or no shows will be charged a \$15.00 fee.
Cancellation of club membership will require a written notice, 30 days in advance, and is subject to an administration fee of \$30.00

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SKIN CARE CLIENT QUESTIONNAIRE

Name: _____ Birth date: _____

Address _____

City _____ State _____ Zip Code _____

Home Phone Number () _____ Cell Phone Number () _____

E-mail _____

Have you ever had a facial before?
If yes, what did you like most about your facial?

How did you hear about our office? (Fax, Newspaper, TV, and Coupon) or referred by: _____

Have you ever had an allergic reaction to products you have applied on your skin?
YES NO

If YES, what products? _____

How often do you cleanse?

Once a day Twice a day more Never

Which products do you use?

Cleaners	Bar soap
Special	Sunscreen SPF
Exfoliators (scrubs, AHA's, Ect.)	Toners
Masks	Moisturizers

Please check ANY conditions which you have had or are now experiencing:

Cancer	High Blood Pressure	Low Blood Pressure
Currently Pregnant	Metabolic Disorders	Silicone or Zyderm Injections
Hepatitis	Hypoglycemia	Sugar Diabetes
Heart Problems	Hysterectomy	Thyroid (over / under)
None	Other _____	

Have you ever undergone treatments from a Dermatologist?

Yes No

If Yes, When? _____ For what condition? _____

Have you undergone: (check all that apply)

- Plastic Surgery
- Chemical Peel
- Dermabrasion

Are you currently experiencing any excessive or abnormal stress?

Yes NO

Is there a history of Acne in your family?

Yes NO

How much sun exposure do you get per day?

Before 10:00 am and / or after 3:00pm
During the hours of 10:00am to 3:00pm

Do You use tanning booths?

Yes No

Do You Smoke?

Yes No

How much water do you drink a day?

Other Fluids consumption:

Coffee	Tea (caffeinated)
Colas	Alcohol

Receive a complimentary mini facial by simply joining our Hand's on club today. Ask your therapist for more details.

You are waiving right in understanding that you may experience some side effects, including temporary redness; to work performed by the practitioner. We will do everything possible to keep this at a minimum.

Client Signature

Date

**** ALL OUR PRODUCTS ARE ORGANIC: NATURAL HYPOALLERGIN****