Cypress Bend

GOLF RESORT, SPA & CONFERENCE CENTER

Name: ______________________________ Service____________________

Address____________________ City__________ State_____ Zip Code__________

Phone(h)__________________ (w)________________ (c)_________________

E-Mail Address______________________________ Birthday____________

Within the last year have you been under a dermatologist or other physicians care? NO YES

Within the last nine months have you undergone any surgeries? NO YES
If Yes please specify:____

Have you had any health problems past or present? NO YES
If yes please specify:____

Do you Smoke? NO YES

Do you follow a restricted diet? NO YES

Do you wear contact lenses? NO YES

Do you have metal implants, pacemaker or body piercings? NO YES

Rate you level of stress on a scale of 1-4 (1=low, 4=high) 1 2 3 4

Please list any medications, supplements, vitamins, diuretics, slimmings tables etc., that you take

____

Do you ever experience skin breakouts? NO YES

Do you ever experience oily shine during the day? NO YES

Do you experience a burning, itching sensation on your skin? NO YES

Have you ever experienced a reaction to any of the following?

Cosmetics Medicine Iodine Pollen Food Animals Fragrance
Hydroxy Acids Sunscreens
Other:____

Are you pregnant or trying to become pregnant? NO YES

Do you have any special skincare problems pertaining to your face or body? NO YES
If yes please specify:____

What skin care products are you currently using:

____
____
____
____

Have you ever had chemical peels, microdermabrasion or any resurfacing treatments? NO YES

If yes how long ago?

Do you sunbathe or use tanning beds? NO YES

Do you burn easily in moderate sunlight ? NO YES

Do you have a tendency to redness? NO YES

Do you suffer from sinus problems? NO YES

What are your skincare goals?____

____
____
____

I understand that the facial/body treatments I receive are provided for the basic purpose of relaxation. I further understand that the facial/body treatments I receive should not be construed as a substitute for medical examination, diagnosis or treatment. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist should I neglect to do so.

Client Signature:______________________________ Date:____________________

Therapist______________________________ Date:____________________