Dr. Robert S. Kinsella
Butterfly Landing
MEDI-SPA

PLEASE PRINT CLEARLY

Name_____Date_____
Address_____City_____Zip_____
Phone_____ Alt phone _____Occupation_____
Date of Birth_____ E-mail _____
(we occasionally send coupons & news)

Whom may we thank for referring you? _____

Lifestyle

How many hours do you sleep per night? ……How often do you exercise?……
On a scale from 1 (low) to 10 (high), how would you rate your stress level? ……

Health/Medical

Are you basically in good health?..... Physicians Name / Dermatologist…..……
Please list all medications you take regularly. Include hormones, vitamins, etc:
……
……
Please list any allergies…….
……
How much water do you drink daily? .....
Please check any health conditions, which you have had in the ***last three years*, or are now experiencing**

○Hepatitis	○Muscular conditions	○Fibromyalgia
○Asthma	○Claustrophobia	○Epilepsy
○High/low blood pressure	○Hormonal disorders	○Hypoglycemia
○Hysterectomy	○Thyroid Disorders	○Recent Illness_____
○Lack of Normal Skin sensation	○Multiple Sclerosis	○Metal Implants_____
○Recent Operation	○Smoking	○Whiplash
○ Type 1 Diabetes	○Type 2 Diabetes	○Thrombosis or Phlebitis
○Heart problems	○Cancer	○Pregnancy_____
○Nursing	○Arthritis	○Chiropractic Care
○HIV/AIDS	○Kidney Disease	Date of last treatment_____
○ Circulation Disorders	○Joint Replacement	Area Treated_____
○Varicose Veins	○Numbness/Tingling	○Skin Conditions

If any of the above areas are checked, please provide necessary details:
……
……
Comments or additional information we need to know about your health:
……
……

FOR MASSAGE CLIENTS ONLY

*I understand that Massage Therapy is meant to reduce stress and is not a replacement for a physicians care. Initials*_____
** Please proceed to the end of this form and sign at the bottom of back page and return to the receptionist.*

FOR FACIALS, WAXING, EPI-GEL, SPA TREATMENTS, MICROCURRENT, MICRODERMABRASION and CHEMICAL PEEL CLIENTS

What are your concerns?
What is your specific concern about your skin? ……
How long have you noticed your condition?……...
Is this an ongoing or temporary condition?……..
Have you ever received a salon skin care treatment?……...
What were the results?……...
Do you ever experience…Flakiness? _____ Tightness? ___ Dryness?_____ Oily shine?_____

Home Skin Care Regime
Describe in detail (using product brand names) how you are presently caring for your skin:
……
……
……
……
……
Have you ever undergone treatment from a dermatologist? Yes / No If yes, when?……
For what type of condition?……..Any side effects?……

Within the last month have you used any of the following?

○*Retin-A*	○*Antibiotics*	○*Laxatives*
○*Accutane*	○*Oral Contraceptives*	○*Diuretics*
○*Blood Thinners*	○*Hormone Replacements*	○*Beta Hydroxy Acids(BHA)*
○*Alpha Hydroxy Acid (AHA)*	○*Renova*	○*Benzoyl Peroxide*
○*MetroGel or Creams*	○*Differin*	

Have you ever undergone plastic surgery? Yes / No If yes, when?……where?……..

I certify that the above statements are true and correct and that I having been advised and fully informed by the licensed estheticians/massage therapists about the nature of the process proposed, to be performed by them, and hereby authorize and direct them to perform such procedures as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that (1) I have read, understand and fully agree to the foregoing (2) Give consent to the proposed process that has been satisfactorily explained to me and I have all the information that I desire (3) I hereby give consent and authorization voluntarily and release the establishment and its agents of any claims that I have or may have in the future in connection with the described application. If a cancellation is necessary, we require 24 hours notice or a 25% service fee will apply.

Signature_____ Date: _____