Bella Soul Spa

Name_____ Date_____
Email_____ Date of Birth_____
How did you hear about us? _____
Address_____City_____State_____Zip_____
Phone (to be used for reminder/follow up calls) _____
Emergency Contact_____ Phone_____

Reserved Treatment Selection: ____ Facial ____ Massage ____ Spa Body Treatment ____ Waxing ____ Lash/Brow Tint ____ Glo Minerals Makeup ____ Ionic Foot Detox

For Face:

Skin Type:

____ Mature ____ Dry ____ Combination/Oily ____ Sensitive ____ Rosacea ____ Acne

What are your skin concerns?

____ Sun Damage ____ Dehydration ____ Sensitivity ____ Hyperpigmentation ____ Scars
____ Dull Complexion ____ Enlarged Pores ____ Loss of Elasticity ____ Uneven Texture
____ Acne ____ Black Heads ____ Dilated Capillaries ____ Rosacea

Have you used Accutane, Retin-A, Renova, received a deep chemical peel, facial surgery or laser treatment within the last 18 months? ____ Yes ____ No

***Waxing Disclaimer:** waxing may cause: bruises, scabs, scarring, redness, hyperpigmentation or pimples. Waxing of soft tissue may cause skin to tear, resulting in need for medical attention * **Please Initial _____**

For Body:

What are some of your concerns?

____ Muscle Tension ____ Stress ____ Discomfort/Pain ____ Arthritis ____ Dehydration
____ Dry Skin ____ Circulation ____ Loss of Elasticity & Firmness

List areas you would like extra attention: _____
List areas you would like to avoid:_____
Desired Massage Pressure: ____ Light ____ Medium ____ Firm

List all medications and supplements:_____
_____
List any surgeries, accidents, allergies or illnesses:_____
_____
(If you need more space, please use the back of this form)

Women: Are you pregnant? ____ Yes ____ No

Cancellation Policy

Your appointment is a special time reserved just for you and we hope you do not have to cancel. However, in the case that you do need to cancel or reschedule, please let us know 24 hours ahead of your scheduled appointment time to avoid being charged 50% of your scheduled treatment(s). Future appointments may not be made until fee is paid in full. **Please Initial:_____**

Consent For Care

It is my choice to receive treatment and I give my consent. I have reported all health conditions and medications that I am aware of and will inform my therapist of any changes in my health.

Signature_____Date_____
Parent/Guardian Signature if under 18 years of age: _____