

Guest Information



Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Date of Birth: _____

Email: _____

- I do wish to receive promotional e-mails or announcements of special events from the West Spa.

Medical Info



Yes No

- Do you have any allergies?
- Are you pregnant? # of weeks? _____
- Do you have high blood pressure or suffer from any heart conditions? Please explain: _____
- Do you have any medical conditions or special needs? Please explain: _____
- Are you currently taking any medication? Please list: _____
- Do you have active cancer? If yes, are you currently undergoing:
 chemotherapy or radiation
- Do you have phlebitis, varicose veins, or bruise easily?
- Do you have any skin infections, nail fungus, or rashes?

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Please complete the section(s) below corresponding to the treatment you are having today:

Massage & Body Treatments

Yes No

- Do you suffer from epilepsy or seizures?
- Have you recently had surgery? Please explain: _____
- Have you had any fractures/sprains in the past two years? Please explain: _____
- Do you have slipped/herniated disks or any unexplained numbness or tingling?
- Do you have soreness in a specific area? Please list: _____

Please list any areas you would like the therapist to avoid: _____

Acknowledgment & Waiver

Please read and sign the following; then complete the appropriate section(s) within this brochure. Any questions you answer "yes" to will be discussed with you prior to your session.

I understand that the spa service I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the service provider so that the pressure and/or stroke may be adjusted to my level of comfort.

I further understand that spa services should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapist/cosmetologists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session (s) should be construed as such.

Because spa treatments should not be done under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the service provider updated as to any changes in my medical profile, and understand that there shall be no liability on the service provider part should I forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and

I will be liable for payment of the full scheduled appointment.

Signed: _____ Date: ___/___/___ Practitioner: _____ Date: ___/___/___

Manicure & Pedicure Rituals

Yes No

- Do you have any skin infections, nail fungus, or rashes?
- Do you have diabetes?
- Are there any areas that should be avoided? Please list: _____

Facial Treatments

Yes No

- Do you have Rosacea or any skin sensitivities?
- Are you using any oral/topical prescriptions for any skin conditions?

If you have checked "Yes" for any of the above, please explain: _____