**Spa Health Information**

Date:

Patient Name: Gender:Male Female

Address: Email:

City: State: Zip:

Email:

Emergency Contact:

1st Name: Relationship:

Phone: Cell Phone:

**Primary Health Care Provider**

Name: Phone:

Address:

City: State: Zip:

**Current Health Information**

1. Please list all conditions currently monitored by a health care provider.

1. Please list the medications you took today (include pain relievers and herbal remedies).

**Current Health Information**

1. Please list the medications you took in the last 3 months.

1. Please list and briefly explain (including dates and the treatment received) the following:

Surgeries

Accidents

Major illnesses

Tobacco Use  Current  Past Comments

Alcohol Use  Current  Past Comments

Drug Use  Current  Past Comments

Are you currently menstruating?  Yes  No

Have you received a spa treatment before?  Yes  No

If yes, what types of spa treatments have you received?

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**Current and Previous Conditions**

Please check all current and previous conditions and give a brief explanation, if appropriate, in the comments section at the end of this form.

Current/Past Current/Past Current/Past

Headache Aversion to cold Stroke

Pain Claustrophobia Lymphedema

Sleep disorders Rheumatoid arthritis High BP

Fatigue Osteoarthritis Low BP

Infections Spinal problems Poor Circ.

Fever Disc problems Swollen ankle

Sinus condition Lupus Varicose vein

Athlete’s foot Tendonitis, bursitis Asthma

Warts Fibromyalgia Bowel Dys.

Skin sensitivities Dizziness, ringing in ears Bladder Dys.

Sunburn Mental confusion Abd. Pain

Burns Numbness, tingling Thyroid Dys.

Bruises Neuritis Diabetes

Aversion to scents Neuralgia Pregnancy

Aversion to oils Sciatica, shooting pain Cancer

Allergies Depression Fibrotic Cysts

Sensitivity to detergent Anxiety, panic attacks Phlebitis

Aversion to heat Heart disease Pacemaker

Skin conditions Blood clots Raynaud Syn.

Other conditions:

Comments:

Therapist’s Name: Signature:

Date:

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