# Renu Day Spa

## Inclusive Health History

At Renu Day Spa, our philosophy is inclusive. We believe that by combining the best of topical skincare, internal nutrients and emotional self-care we can help you achieve whole body health. Please take a moment to fill out the questionnaire below; your answer will allow your service provider to target your specific conditions to provide you with a truly personalized experience.

Name:_____ Birthdate:_____

Contact in Case of Emergency (Name & Phone #):_____

Occupation/Work Place:_____

**GENERAL HEALTH** (check all that apply):

___ Heart Problems ___High/Low Blood Pressure ___Hormonal Problems ___Diabetes

___Skin Cancer ___ Over/Under Active Thyroid ___Autoimmune Deficiency

___Skin Allergies (please list)_____

Are you currently under a physician's care?_____

List any medication_____

List any other health problems that your technician should be aware of_____

_____

| **PLEASE INDICATE THE FOLLOWING** | **YES** | **NO** |
|---|---|---|
| Do you have any metal implants or a pacemaker? | ____ | ____ |
| Do you wear contact lenses? | ____ | ____ |
| Do you smoke? | ____ | ____ |
| Do you have sinus problems? | ____ | ____ |
| Have you recently had X-ray? | ____ | ____ |
| Recent injury? | ____ | ____ |
| Briefly explain the type of injuries and when_____ | | |
| Recent car accident? | ____ | ____ |
| Have you had a massage before? | ____ | ____ |
| **Female Clients Only:** | | |
| Are you, or are you trying to become pregnant? | ____ | ____ |
| Are you pre or post menstrual (3 days)? | ____ | ____ |
| Are you in your second (or third) trimester? | ____ | ____ |

**Have you recently had**:

___ Laser Surgery ___Sunburn or Excess Sun Exposure ___Chemical Peel
___Microdermabrasion ___Tanning Bed Exposure ___Waxing or Hair Removal

Other? Please Explain:_____
Do you have a tendency towards redness, rashes or hives?_____

**Are you using any of the following**:

___Retin A/Renova ___Vitamin C Products ___Other Topical Medications
___Accutane ___Alpha Hydroxy Products Explain:_____
___Other:_____

Which brands are you currently using on your skin?
Cleanser:_____ Toner:_____ Treatment (AHA, Vitamin C, Other):_____
Daily Moisturizer:_____ Evening Moisturizer:_____ Eye Cream:_____
Masque:_____ Sunscreen_____ Other:_____
Any past product reaction? Explain:_____
What are your primary skin concerns?:_____

**INTERNAL HEALTH**

Are you currently taking any of the following?
___Birth Control Pills ___Vitamin Supplements ← If yes, which ones:_____
___Hormone Therapy ← If yes, which kind?_____
Do you feel that you have a balanced diet? If no, what would you like to change?:_____
_____

**EMOTIONAL CARE:**

Are you under a lot of stress?_____ Rate Stress 1-10 (1 being the least amount of stress)_____
Do you exercise regularly?_____ If yes, how many times a week?_____
In what areas of your body do you carry most of your tension and stress?_____
When was the last time you did something for yourself?_____
Is there anything about yourself that you would like to improve or change?_____
_____

Do you participate in group activites?_____
How did you hear about your facility?_____