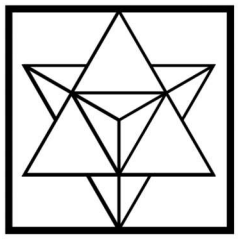
SOULSTONE SPA & APOTHECARY



Skincare Intake

Please complete this form. This information is critical to your session(s) as it may affect the focus and outcome of it. All information disclosed will be kept for session purposes only and in strict confidentiality.

Name _____ Birth Date _____

Address _____ Apt/Suite _____

City _____ State _____ Zip _____

Cell _____ Home_____

Occupation _____ E-Mail _____

Emergency Contact _____ Phone _____

If you are receiving a facial, what are you most interested in today?

☐Relaxation/Pampering

☐Deep Cleansing/Purification

☐Hyperpigmentation

☐Hydration / Dryness

What is your skin type?

☐Oily ☐ Dry ☐Combination ☐Normal

How did you hear about Soulstone Spa & Apothecary?

☐ Internet ☐ Advertisement ☐ Family / Friend _____ ☐ Social Media _____

16 Madison Sq West (1115 Broadway), 10th Floor
(347) 766 – 1936
Info.Soulstone@gmail.com

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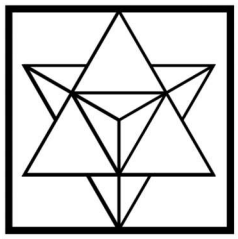

Skincare Intake

YES	NO	
☐	☐	Are you currently under the care of a Dermatologist?
☐	☐	Are you using any oral or topical medications that would be relevant to your session today? If so, what? (i.e. Retin A, Tazorac, Differin, etc) _____
☐	☐	Have you used any Alpha Hydroxy Acid or Glycolic products in the past 48-72 hours?
☐	☐	Have you had any Microdermabrasion, Dermablading, or Dermabrasion in the past 2 weeks?
☐	☐	Have you ever had a cold sore?
☐	☐	Have you had any chemical peels within the last week? Describe _____
☐	☐	Have you been over exposed to the sun, or been on a tanning bed in the last 24 hours?
☐	☐	Have you had any cosmetic tattooing in the area to be treated? Where? _____
☐	☐	Do you have any metal, or other, implants? Describe _____
☐	☐	Do you have any allergies to *aspirin*, fragrances, essential or plant oils used in skin care products? If so, what? _____
☐	☐	Have you had any recent hair removal treatments in the area to be treated? If so, what and where? _____
☐	☐	Have you had any Botox or filler injections? If so, when and where? _____

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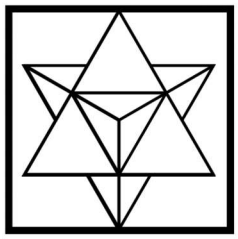

Skincare Intake - Oncology History

What is your cancer diagnosis?

_____
_____

Select and describe all cancer related treatments you are or have undergone. List all side effects as well.

□ Surgery

□ Lymph nodes removed? # _____

_____
_____
_____
_____

□ Chemotherapy

□ Ongoing? Date of last dose? _____

_____
_____
_____
_____

□ Radiation Therapy

□ Ongoing? Date of last dose? _____

_____
_____
_____
_____

□ Immunotherapy

_____
_____
_____
_____

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Skincare Intake - Oncology History

□ Hormone Therapy

□ Ongoing? Date of last dose? _____

_____
_____
_____
_____

Are you currently in remission? Yes □ No □

Has your doctor approved massage during your treatment? Yes □ No □

Please provide your oncologist's contact information.

Name: _____

Address: _____

Phone: _____

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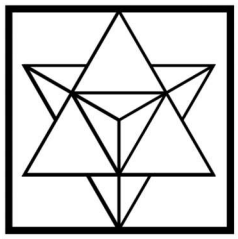

Skincare Intake

****If you experience any pain during the session(s), please immediately inform the therapist, so that the work can be adjusted to your level of comfort.**

By signing below, I state that all the information on this form is accurate that I understand the services I receive are provided for the basic purpose of relaxation and stress reduction. I am aware that facials and waxing can increase my skin's sensitivity and if I have an undisclosed allergy to any ingredients used, known or unknown to me, I will not hold my therapist responsible. I understand that if I am using Accutane, Retin A, retinol, or any exfoliants on my skin prior to my session that it can cause irritation and that I will inform my esthetician prior to my waxing or facial services. I agree to keep the spa updated as to any changes to my medical profile, and I understand there will be no liability on the spa or the therapist's part if I fail to do so.

Please indicate if signing for a minor. Yes ____ No ____

Signature _____

Date _____

Office Use Only:

Reviewer: _____ Date: _____

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