newbeginnings
wellness center and spa

New Spa Client

Name: _____

Address: _____ Apt #_____

City: _____ State: _____ Zip:_____

Home phone#: _____ Cell phone#: _____

Work phone#: _____ Birthday Month/ Day /Year _____/_____/_____

How did you hear about us? _____

If by Internet, what was the link? _____

Are You Redeeming a Gift Certificate or Applying a Promotion?
Please present your Gift Certificate at check-in, prior to your services.

For all services, we require **24 hours notice** in the event of cancellation of single treatments and **48 hours notice** for Multiple Service or Spa Packages. If full notice is not provided, we will bill for 100% amount of the services reserved or a $50 fee for Botox/filler appointments.

We recommend arriving a few minutes prior to your appointment to ensure your service begins on time. Please keep in mind that if you arrive more than 15 minutes late and there is insufficient time to complete your service, the service will be canceled or rescheduled and you will be billed for 100% amount of the services reserved or a $50 fee for Botox/filler appointments.

Spa Etiquette:

Please keep in mind that there are treatments in progress. We request that you turn off your cell phone and lower your voice. Please, for your peace of mind, keep your valuables with you or you may request to use one of our complimentary lockers. New Beginnings is not liable for loss or theft of items.

Signature: Date:

_____

Spa Client Intake Form

Name:_____ Date:_____ Male/Female

Date of Birth:_____ Occupation:_____

*Have you had a Facial before? yes / no If yes, where and how long ago?_____

*Have you ever had Chemical Peels, Microdermabrasion or any resurfacing treatments? yes / no

If yes, where and how long ago?_____

*Have you ever had cosmetic injectable treatments (e.g., Botox, dermal fillers, Kybella, etc.)? yes / no

If yes, where and how long ago?_____

*Are you Pregnant? yes / no If yes, how far along? _____

*Do you Smoke? yes / no if yes, how many a day? _____

*Do you Drink Coffee or Sodas? yes / no If yes, how much a day?_____

*How many glasses of Water do you drink a day?_____

*Exposure to the sun (please circle): Never...Light...Moderate...Excessive...

*Do you have: Allergies to latex? yes /no

Other allergies? yes/no_____

*Do you take any Medication (topical or oral) for acne: yes / no _____

*Have you used Accutane in the past 12 months? yes / no

*Are you currently on any medications/supplements? yes / no

Please list:_____

*Are you currently using any products that contain the following ingredients? (Circle all that apply)

Glycolic acid...**Lactic acid**...**Exfoliant Scrubs**...**Alpha Hydroxy acids**...**Vitamin A derivatives**...

*What skin products are you currently using? (circle all that apply)

Soap...**Cleanser**...**Toner**...**Moisturizer**...**Serum**...**Mask**...**Exfoliant**...**Eye products**...

Other (please explain): _____

*Do you have any of these conditions? (circle all that apply)

Epilepsy...**Heart condition**...**Pacemaker/ICD**...**Skin cancer**...**Skin Diseases**...**Recent operations**...

Other (please explain): _____

*Do you have any treatment goals? _____

*Is there anything else that we should be aware of before we start working together?

_____

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Signature: _____ Date:_____