Kanani PEARL SPA

In order to best serve you, we ask that you take a few minutes to fill out this intake form.
All information will be kept 100% private and confidential.

Name

Date of birth

Address

City

State

ZIP

Phone

Email

Emergency Contact

Emergency Contact Phone

Please check any of the conditions that apply to you:

- ☐ Cancer
- ☐ Thrombosis
- ☐ Headaches
- ☐ Tension
- ☐ Phlebitis
- ☐ Metal implants
- ☐ Neck pain / injury
- ☐ High blood pressure
- ☐ Diabetic
- ☐ Epilepsy
- ☐ Swelling / sensitivity
- ☐ Heart problems
- ☐ Pregnant
- ☐ HIV / AIDS
- ☐ Asthma
- ☐ Pacemaker
- ☐ Allergies
- ☐ Bee stings
- ☐ Wearing contact lenses

Please list any medications you are currently taking.

Have you had silicone, collagen, restylyne or botox injections?

☐ Yes ☐ No If yes, when? _____

Do you have any other medical conditions that we should be aware of?

What are your desires / expectations for your visit?

FACIAL RELEASE What is your facial skin type?

☐ Oily ☐ Dry ☐ Normal ☐ Sensitive

I understand that when I receive a facial or body mask, active ingredients may come into contact with my skin and may cause temporary redness or discomfort, and that I am accepting responsibility for my skin's reaction.

_____ (Please initial)

WAXING RELEASE I am presenting using:

☐ Retin_A ☐ Accutane ☐ Glycolic Acid ☐ Renova ☐ None of these

I understand that I am responsible for any trauma and/or reactions (scabbing, redness or pimples) that I may experience from the service known as waxing. I also understand that if I begin to use any of the products mentioned above, and do not inform my technician, I am accepting responsibility for my skin's reaction.

_____ (Please initial)

MASSAGE RELEASE

I understand that specific medical conditions may state that massage is contra-indicated and that a physician's referral might be required before receiving treatment. I understand that the massage/bodywork that I receive is provided for the basic purpose of relaxation and relief of muscular tension, and is not a substitute for medical attention. I understand that it is my responsibility to communicate with my therapist any pain or discomfort I experience during my treatment so that he/she can adjust pressure and depth to my comfort level.

_____ (Please initial)

Client Signature _____ Date _____

Therapist Signature _____ Date _____