



INN ON THE TWENTY

DINE • INN • SPA

Guest Form

Date	mm/dd/yy	Date of Birth	mm/dd/yy	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Last Name		First Name			
Address	Apt/unit	City	Province	Postal Code	
Home Phone	Bus. Phone		Mobile Phone	Email	

The following profile should be completed for all clients. This is to correctly evaluate the client's special needs in both the skin care services and for home maintenance. This information is completely confidential and to be used only for this analysis.

1. How did you hear about our Spa? Publicity Reference Mailing Gift Certificate Others. Please specify _____
2. When was your last Aesthetic Service? _____ **Massage** _____
mm/dd/yy mm/dd/yy
3. a) What is the purpose of your visit? Face Care Body Care Pedicure Manicure Massage Hair Removal
 Others. Please Specify _____
- b) What are your expectations? Prevention Maintenance Repair Others. Please specify _____
- c) Do you have insurance coverage for the massage? Yes No
4. What is your occupation? _____
5. Where do you usually purchase your products? Retail Store Spa/Beauty Salon Pharmacy Perfumery
 Shopping network Others. Please specify _____

<p style="text-align: center;">Face</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cleansing Milk <input type="checkbox"/> Toning Lotion <input type="checkbox"/> Gommage/Exfoliant <input type="checkbox"/> Serum <input type="checkbox"/> Day cream <input type="checkbox"/> Night cream <input type="checkbox"/> Mask <input type="checkbox"/> After hair removal cream <input type="checkbox"/> Lip products <input type="checkbox"/> Others _____ 	<p style="text-align: center;">Body</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shower Gel <input type="checkbox"/> Body Gommage/Exfoliant <input type="checkbox"/> Body lotion/Cream <input type="checkbox"/> Slimming cream/Contouring <input type="checkbox"/> Slimming serum/Contouring <input type="checkbox"/> Firming body cream <input type="checkbox"/> Firming Bust Cream <input type="checkbox"/> After hair removal cream <input type="checkbox"/> Cream for stretch marks <input type="checkbox"/> Others _____ 	<p style="text-align: center;">Hand</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hand Cream <input type="checkbox"/> Gommage/Exfoliant <input type="checkbox"/> Others _____ <p style="text-align: center;">Foot</p> <ul style="list-style-type: none"> <input type="checkbox"/> Gommage/Exfoliant <input type="checkbox"/> Body Lotion <input type="checkbox"/> Others _____ <p style="text-align: center;">Relaxation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bath Products <input type="checkbox"/> Others _____
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7. Which skin care brand(s) do you usually use? _____

8. At the present time, are you undergoing regular treatments of any kind or seen regularly by others?

Chiropractor Osteopath Physiotherapist Others. Please specify _____

9. Please list all medications you are currently using and reason for use? _____

10. Do you have any allergies? Yes No If so, please specify. _____

11. Please indicate any sore regions of the body: _____

12. Are you undergoing regular treatments or seen regularly by a dermatologist? Yes No

If so, please specify the purpose. _____

Medical History

Please check if you currently have (C) or had in the past (P) any of the following

Cardiovascular

- Heart Problems (Pacemaker)
- Hypertension
- Low blood pressure
- High blood pressure
- Circulatory problems
- Stroke (CVA)
- Varicose Veins
- Dizziness
- Chest Pain
- Others _____

Respiratory

- Emphysema
- Asthma
- Chronic cough
- Bronchitis
- Difficulty breathing

Neurological

- Epilepsy
- Multiple Sclerosis
- Loss of Sensation

Muscles/Joints

- Arthritis
- Osteoporosis
- Fractures/Dislocation
- Soft Tissue Injuries
- Fibromyalgia
- Metallic implants
- Automobile accident
- TMJ

Gastrointestinal

- Prolonges Constipation
- IBS
- Chronic Abdonimal discomfort

Others

- Diabetes
- Cancer
- HIV/Aids
- Hepatitis
- Pregnancy
- Menopause/Pre menopause
- Claustrophobia
- Numbness
- Thyroid condition Hypo Hyper
- Headaches/Migraines
- Others _____

Please provide us with you medical physician's name and phone number.

Name: _____ Phone: _____

I confirm to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client's signature

mm/dd/yy

