Everything Zen

FACIALS

Welcome to Everything Zen. It is my commitment to provide you with holistic health services that enhance your body's natural ability to heal. All therapies are customized to your unique needs. Together, we will create a plan based on your lifestyle and personal goals to optimize your health and wellness. Thank you for the opportunity to share in your well-being and relaxation.

Yours in natural health,
Holly Potter, L.E., L.M.T.

Financial Policies for Everything Zen:

Dear friends and valued clients,

Both of our time is valuable, and your appointment time is held especially for you. We understand that life occasionally happens, and there may be a need to reschedule. We appreciate more than 24 hours notice, but in the event that less than 24 hours notice is given, a $50 fee will be charged to you, and payable upon your next visit. As of July 1st, 2011, tax will be charged on facial and waxing services. (All other services are non-taxable.) All gift certificates are FINAL, and can be used toward any product or service at Everything Zen. Due to Department of Health regulations, all opened retail purchases are NON-REFUNDABLE.

Thank you for your understanding, and by signing below, you agree to our financial policies.

Signature: _____

Today's Date: _____

Everything Zen

FACIAL INTAKE FORM

Name_____ Phone ( )_____ Cell ( )_____

Address _____

City _____ State ___ Zip _____ E-Mail _____

Referred by _____

Emergency Contact _____ Relationship _____ Phone ( )_____

1. Is this your first facial? Yes No
2. What is your main concern with your skin?
   _____
3. Are you presently under a physician's care for any current skin condition or other problems? If yes, please explain _____
   _____
4. Are you pregnant? Yes No
5. Are you taking birth control pills? Yes No
   If so, what type? _____
6. Are you presently using (or used in the past): Azelex, Differin, Renova, Retin-A, Tazarac, Glycolic, or Alpha Hydroxy Acids? If so, when and for how long? _____
7. Are you now using or have you ever used Accutane? Yes No
8. Are you presently taking any medications? If so, please list: _____
   _____
9. Do you wear contact lenses? Yes No
10. Do you smoke? Yes No
11. Do you have any allergies to cosmetics, food or drugs? If so, please list: _____
    _____
12. Have you had skin cancer? Yes No
    If so, what and when? _____
    _____
13. Do you often experience stress? Yes No
14. What skin care products do you presently use?
    _____
    _____

Please circle if you are affected by or have any of the following:

Anxiety	Asthma	Cardiac Problems	Depression	Eczema
Epilepsy	Fever Blisters	Headaches-Chronic	Hepatitis	Herpes
High Blood Pressure	Hysterectomy	Immune Disorders	Lupus	
Metal Bone Pins/Plates	Pace Maker	Sinus Problems	Skin Disease	

Please explain above problems or list any other significant issues _____
_____

Draping will be used during the session—only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian.

I understand that the services offered are not a substitute for medical care and any information provided by the therapist is for educational purposes only, and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

I, _____(print name) understand that the facial I receive is provided for the basic purpose of relaxation and natural skin care. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that a facial should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client_____ Date_____

Signature of Therapist_____ Date_____