VERONICA MARGO
SPA

Welcome to VERONICA MARGO SPA

Please help us to serve you by completing the client information form

Date_____/_____/_____
MO DAY YR

First Name: _____

Last Name: _____

Salutation (please indicate one) Mr. / Mrs. / Ms. / Miss / Dr.

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

email address:_____ I wish to receive

Veronica Margo Spa newsletter/internet special notices. Yes / No

Gender_____ Date of Birth _____/_____/_____

_ Occupation_____

How did you learn of our spa? _____ or Referred by _____

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MEDICAL HISTORY

Have you ever had a reaction to personal care products? Yes No
If yes, please list_____

Are you allergic to any medications?
If yes, please list_____

Are you taking any medications at present?
If yes, please list_____

Are you pregnant? Yes No If yes how many month are you

Do you have a history of any of these health conditions?

High Blood Pressure	Yes	No	Diabetes	Yes	No
Bleeding Problems	Yes	No	Seizure	Yes	No
Heart Problems	Yes	No	Cancer	Yes	No
Claustrophobia Skin	Yes	No	Thyroid Problems	Yes	No
Condition	Yes	No	Radiating Pain	Yes	No
Nail Fungus	Yes	No	Systemic Disease	Yes	No
Spinal Problems	Yes	No	Varicose Veins	Yes	No
Blood Clots	Yes	No	Arthritis	Yes	No
Acute Injury	Yes	No			

If yes, please elaborate_____
_____

Have you ever had surgery? Yes No
If yes, please explain_____

Do you have any other medical conditions of which we should be aware? Yes No If yes, please list_____

Signature: _____ Date: _____