

The Oasis

A Healing Spa for the Body, Mind, and Soul.

318 S. Scenic Hwy.

Suite # 105

Lake Wales, FL 33853

(863) 232-6968

MM#20448

Name: _____ D.O.B: _____ Sex: Female__ Male__
Address: _____ City: _____ State: _____ Zip _____
Telephone #: Home(____) _____ Cell(____) _____
Employer: _____ Occupation: _____
Work #: (____) _____ E-Mail Address: _____
In Case of Emergency, Please Notify: Name: _____
Relationship: _____ Telephone: _____
Would you like to receive our coupons and special offers by mail or e-mail: Yes__ No__
Please let us know how you heard about us: _____

Please take a moment to carefully read and fill out the following information. If you have a specific medical condition or specific symptoms, some Skin Care may be contraindicated. A referral from your primary care provider may be required prior to receiving therapy.

Have you ever received a professional Facial or Skin Care before: Yes__ No__

If yes, when was your last therapy: _____

What results would you like to achieve with today's session: _____

Please list any of the following conditions or symptoms that you may have or suffer from:

Yes__ No__ Do you have a pacemaker?

Yes__ No__ Are you pregnant?

Yes__ No__ Are you on the pill?

Yes__ No__ Are you taking any Hormones?

Yes__ No__ Any menopause problems?

Yes__ No__ Are you claustrophobic?

Yes__ No__ Are you wearing contact lenses?

Yes__ No__ Do you have high blood pressure?

If yes, is your blood pressure regulated with medication?

Yes__ No__

Yes__ No__ Do you suffer from epilepsy or seizures?

Yes__ No__ Do you suffer from joint swelling?

Yes__ No__ Do you have any contagious diseases?

Yes__ No__ Do you suffer from stress?

Yes__ No__ Do you have any allergies?

If yes, please list: _____

Yes__ No__ Do you bruise easily?

Yes__ No__ Any injuries in the past two years?

If yes, please explain: _____

Yes__ No__ Any broken bones in the past two years?

If yes, where: _____

Yes__ No__ Do you have cardiac or circulatory problems?

Yes__ No__ Are you ticklish or sensitive to touch?

If yes, please list area(s): _____

Yes__ No__ Have you ever had surgery?

If yes, please explain: _____

Please use the area below to list any other medical conditions, or any medications I should know about:

General Skin Care Information

Yes__ No__ Have you ever had skin cancer?
Yes__ No__ Do you use Retin A?
Yes__ No__ Do you use Accutane?
Yes__ No__ Do you use Glycolic Acid products?
Yes__ No__ Have you ever had an Acid Peel?
Yes__ No__ Do you spend a lot of time in the sun?
If yes, do you normally wear sun block?
What SPF do you use: _____
Yes__ No__ Do you use any home treatment products?
If yes, what Brand do you use: _____
Yes__ No__ Are you using a harsh exfoliate?
Yes__ No__ Do you use any products containing alcohol?

Yes__ No__ Do you feel any burning or itching of the skin?
If yes, list areas: _____
Yes__ No__ Do you have Rosacea?

Do you think your skin is (Please check all that apply):
Oily__ Dry__ Acne Prone__ Aging__
Normal__ Partly Oily__ Or has Enlarged Pores__

What kind of an improvement would you like to see on your skin: _____

Signature _____

Date _____

Skin Analysis

(For professionals use only)

Skin Texture: Fine__ Medium Thickness__ Thick__ Very Thick__
Complexion Color: Pale__ Healthy__ Muddy__ Waxy__ Olive__ Sun Tanned__ Burned__
Dehydrated: Superficially__ Deeply__
Gland Secretion: Normal__ Partly Oily__ Oily__ Deeply Oily__ Acne__ Dry__ Very Dry__
Circulation Problems: Couperose__ Rosacea__
Area: Nose__ Cheeks__ Chin__ Forehead__ Entire Face__
Muscle Tone: Good Contour__ Medium Lack of Tone__ Fallen__
Aging Signs: Deep Expression Lines__ Crow's Feet__ Fine Lines All Over Face__ Falling Eye Lids__

Other Problems:

Scars: Light__ Medium Depth__ Deep__ Areas _____
Pigmentation: Light Freckles__ Dark Heavy Freckles__ Pregnancy Mask__ Birthmarks__ Brown Patches__
Double Chin__ Sensitivity to Heat__ Sensitivity to Products _____