

Client Intake Form



Name _____ Date _____

Address _____ City _____

Birthday (Month/Day) _____ Email _____

Phone _____ Referred By _____

Are you interested in receiving Yolo's newsletters and specials? (circle one) YES NO

Are you pregnant? If so how far along are you? _____

Any major injuries, accidents or surgeries? _____

List any health problems _____

List any medications you take including any topical ointments (such as Retin-A)

What are your areas of concern for your services today? (Examples: relieve back pain, unclog pores, relaxation)

How long has it been since your last massage/facial? _____

For Massage: _____

***Are there any areas of your body that you 'DO NOT' want massaged:**
(Face) (Scalp) (Neck) (Upper Chest) (Shoulders) (Stomach) (Upper back) (Mid back)
(Lower back) (Arms) (Hands) (Side of gluteus) (Legs) (Feet)

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I understand that spa services do not take the place of medical treatment. Spa therapists are not doctors and cannot diagnose, treat illness or disorders. They also have the right to decline services to an individual with (but not limited to) open skin or sores.

If any client shows signs of inebriation, services will be terminated and the client will be liable for payment "In full." I also understand that any illicit or sexually suggestive remarks or advances made by me to an employee of YOLO llc at any point will result in immediate termination of the session and/or removal from the premises. In this case, I will be held liable for payment "In full."

I acknowledge *YOLO llc* maintains a **48-Hour Cancellation Policy**. If I choose to cancel services in less than 48 hours, I am responsible for the full amount of the service fees.

DISCLAIMER: This place of business will not be held liable for any injury or condition that arises from application of massage/facial or spa treatment, despite completion of this form. The form is intended as an assessment tool that is routinely used in the massage/skin care profession and serves as a guide. Your e-mail address will not be sold or given to anyone else.

I have stated all medical conditions and medications.

Signature _____ Date _____

Therapist _____