BELLA VIA
Skin and Body Therapies

BODY + SKINCARE INTAKE FORM

Name:_____ DOB:_____ Age:_____ Gender:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____ Work: _____

Email Address:_____Occupation: _____
(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you originally referred to Bella Via? (Please circle and add note if applicable.)
Dr. Colville Dr. Zavell Website Friend: _____
Other: _____

MEDICAL HISTORY

Please circle any of the following conditions that apply to you:

Arthritis/Rheumatism	Asthma	Back Pain	Blood Clots
Bursitis	Cancer: type_____	Carpal Tunnel Syndrome	Cold Sores
Diabetes	Eczema/Psoriasis	Fibromyalgia	Frequent Headaches
Heart Problems	Hepatitis	High/Low Blood Pressure	Infectious Disease
Immune Deficiency Disease	Joint Problems	Lymph Node Removal	Migraine Headaches
Nail/Foot Fungus	Sciatica	Seasonal Allergies	Smoker
Sunburn/Windburn Face	Thyroid Condition	TMJ	Torn Rotator Cuff
Varicose Veins	Wounds/Infections		

Do you suffer from excessive stress or depression? If yes, please explain: _____

_____

Do you have circulation problems or do you bruise easily? _____
List all allergies and sensitivities including medications: _____

_____

Have you ever had a stroke or any other major injury? If yes, please explain: _____

_____

Do you wear contact lenses? _____
Are you pregnant? If yes, when is your expected due date? _____
Are you breast-feeding? _____
Do you participate in physical/sports activities? If yes, which types and how often? _____

_____

List all surgeries you have had within the last five years: _____

_____

List any medications, herbals, and vitamins that you are currently taking: _____

_____

Do you have any other medical condition(s) that your technician/therapist should know about? If yes, please explain: _____

_____

Do you tan via artificial tanning beds or booths? Yes No
If yes, when was your last visit?_____

BODY SPECIFICS

What are your expectations of the body treatment you will receive today? _____

_____

Do you prefer a light or firm touch with your massage? _____

Are you interested in aromatherapy incorporated into your treatment today? _____

Do you prefer a full-body massage, or do you have specific muscle groups that you would like your therapist to focus on during your massage? _____

_____

Have you had a professional massage before? _____

If yes, when? _____

Do you have any spinal problems? _____

Are you especially sensitive to touch/pressure in any specific areas? _____

Do you have difficulty falling asleep at night? _____

Do you get muscle cramps? If yes, where? _____

SKIN SPECIFICS

What are your expectations of the skin treatment you will receive today? _____

_____

If time allows, would you like to add any extra services to your skincare procedure today, such as waxing or paraffin for the hands and/or feet? _____

How would you describe your skin? (circle all that apply)

Acne Scarred	Asphyxiated	Breakouts	Combination	Comedones
Cysts	Dry	Firm	Florid/Flushed	Freckled
Hyperpigmented	Hypopigmented	Large Pores	Mature	Melasma
Milia	Normal	Oily	Oily T-Zone	Patchy Dryness
Perfume-Stained	Psoriasis	Rosacea	Saggy	Sallow/Yellowed
Small Pores	Sun-Damaged	Thick	Uneven	Wrinkled
Telangiectasia (Broken Surface Capillaries)				

Are you sensitive to alcohol-based products? Yes No

Have you ever had a peel? Yes No

If yes, please describe the type and your reactions to the peel _____

Are you currently having microdermabrasion? Yes No

If yes, how long has it been since your last treatment? _____

Have you recently had laser resurfacing? Yes No

If yes, please describe type and list approximate date _____

Do you have regular cosmetic injections? Yes No

Are you currently using Accutane? Yes No

If yes, how long have you been using it? _____

Are you currently using Tazorac, Retin-A, Renova, or Differin? Yes No

If yes, what strength? _____ How long? _____

How frequently? _____ Where do you apply it? _____

Have you had facial waxing within the last 3-5 days? Yes No

Have you shaved your face within the last 3-5 days? Yes No

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By signing below, I agree to the following statement:

I understand that my body therapy session is provided for the basic purpose of stress reduction, relief from muscular discomfort, and for help in increasing blood, lymph, and energy circulation. I have stated all known medical conditions and I will keep the massage therapist updated on any changes regarding my health. I claim full responsibility for services rendered.

I have stated all known medical conditions and I will keep the esthetician updated on any changes regarding my health. I claim full responsibility for services rendered.

I consent to having "Before" and "After" photographs of said procedure(s) for the purpose of documentation in my file. These photographs **may** _____ or **may not** _____ (please initial one) be used anonymously on our website or in our brochure for advertising purposes.

Signature: _____ Date: _____