

Guest Name \_\_\_\_\_

Date \_\_\_\_\_

### AREAS OF CONCERN

Please advise us of any areas of concern you wish to address in today's treatment. Please check all that apply.

#### SKIN CARE

- Fine Lines
- Dehydration
- Excessive Oil
- Redness, Sensitivity
- Clogged Pores, Acne
- Eyes: Fine Lines, Puffiness

#### MASSAGE

- Stress Reduction
- Anxiety, Irritability, Fatigue, Insomnia
- Headaches
- Muscle Aches and Pains
- Neck, Shoulder, or Back Pain
- Injuries

#### BODY TREATMENT

- Dry or Oily Skin
- Cellulite
- Lack of Tone

#### HAND AND FOOT

- Dry Hands
- Age or Brown Spots
- Rough, Calloused Feet
- Nail Conditions

#### HAIR

- Split Ends
- Color
- Dry Hair/Scalp
- Oily Hair/Scalp
- Body/Fullness

OTHER \_\_\_\_\_

### LIFESTYLE INTERESTS

- Books
- Music
- Candles
- Clothing
- Gifts
- Homeopathic
- Travel
- Outdoors
- Meditation
- \_\_\_\_\_

### PERSONAL CARE GUIDE



P.O. BOX 1776, WILLIAMSBURG, VA 23187-1776  
307 S. ENGLAND ST., WILLIAMSBURG, VA 23185  
1-800-688-6479 OR (757) 220-7720  
www.TheSpaofColonialWilliamsburg.com  
email: TheSpa@cwf.org

Welcome to The Spa of Colonial Williamsburg.  
Thank you for taking the time to complete this Personal Care Guide. Your responses to these questions will help us to serve you better. We hope you enjoy your time with us today.

Guest Name \_\_\_\_\_

Date \_\_\_\_\_



## NEW GUEST INFORMATION

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Cell/Other \_\_\_\_\_  
 Email \_\_\_\_\_

### IN CASE OF EMERGENCY, PLEASE CALL

Name \_\_\_\_\_  
 Phone \_\_\_\_\_

## WAIVER

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage, bodywork, or aesthetic treatments may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

*I understand that massage, bodywork, and facials I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage or body-work should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage, bodywork, or facials should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me are considered sexual harassment and will result in the immediate termination of the session, and I will be liable for payment of the scheduled appointment.*

\_\_\_\_\_  
 Guest Signature

\_\_\_\_\_  
 Date

## MEDICAL INFORMATION

- YES  NO Do you have any allergies?  
 YES  NO Are you pregnant?  
 YES  NO Do you have high blood pressure or any heart conditions?  
 YES  NO Do you have any medical conditions or special needs?  
 YES  NO Are you currently taking any medication or under any medical treatments?

### FOR MASSAGE AND BODY TREATMENTS

- YES  NO Do you have diabetes?  
 YES  NO Do you experience frequent headaches?  
 YES  NO Do you suffer from epilepsy or seizures?  
 YES  NO Do you have soreness in a specific area?

### FOR FACIAL TREATMENTS

- YES  NO Are you taking any oral prescriptions for any skin conditions?  
 YES  NO Are you wearing contact lenses?  
 YES  NO Are you using any topical prescriptions for any skin conditions?  
 YES  NO Do you use retinol or glycolic products?

If you have checked YES to any of the above, please explain \_\_\_\_\_



## THERAPIST-PRESCRIBED AT-HOME CARE ROUTINE

SKIN CARE	am	pm
Therapist _____		
Cleanser _____		
Toner _____		
Exfoliant _____		
Moisturizer _____		
Eye Cream _____		
Mask _____		
Treatment _____		
<b>BODY CARE</b>		
Therapist _____		
Cleanser _____		
Toner _____		
Exfoliant _____		
Moisturizer _____		
Treatment _____		
Essential Oils _____		
<b>MASSAGE</b>		
Therapist _____		
Massage Oils/Essential Oils _____		
_____		
<b>HAND AND FOOT</b>		
Therapist _____		
Exfoliant _____		
Moisturizer _____		
Treatment _____		
Polish _____		
<b>HAIR</b>		
Therapist _____		
Shampoo _____		
Conditioner _____		
Treatment _____		
Styling Product _____		
<b>OTHER</b>		
Therapist _____		

RECOMMENDED  
 NEXT APPOINTMENT