



Sunrise Spa

General Intake Form

Thank you for your interest in becoming a client of Sunrise Spa.
This form is used to collect information about new clients and for internal purposes only.
The information you supply is confidential and will be treated accordingly.

Personal Information

First Name _____ Last Name _____

Email _____ Cell Phone _____

Date of Birth ____MM____DD____YY Age ____ Gender ☐ Male ☐ Female ☐ Other

Height: _____ Weight: _____ Primary Language: ☐ English ☐ Spanish ☐ Other

Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Relation _____ Phone _____

How did you hear about us? ☐ Internet ☐ Yelp ☐ Facebook ☐ Google ☐ Other _____

Are you a member of our Referral Club: Y ____ N ____ Club Number: _____

Medical Information

List your allergies and describe the reactions to your body:

Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____

List any serious medications that you are taking and if you are current:

Medication: _____ Current: Y N	Medication: _____ Current: Y N
Medication: _____ Current: Y N	Medication: _____ Current: Y N



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List any major surgeries, injuries, illnesses, or hospitalizations that you have had:

Description	When	Healed Y or N

Do you currently have any of the following conditions?

Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Insomnia	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Irritable Bowel Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N
Celiac Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Chronic Fatigue Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N	Menopause	<input type="checkbox"/> Y <input type="checkbox"/> N
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizure Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Tremors	<input type="checkbox"/> Y <input type="checkbox"/> N
Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N

By signing below, I hereby acknowledge, agree, and authorize all of the following:

- Accurate Information.** I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
- Release of Medical Information.** Sunrise Spa shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
- Consent for Treatment.** I grant Sunrise Spa permission to use the health information provided for the purpose of evaluating and adjusting my treatments.
- Consent to Communication.** I consent to receiving communications from Sunrise Spa regarding appointment reminders and other necessary appointment related information via phone or email.
- Acknowledgment.** By signing below, I hereby acknowledge, agree, and authorize all of the above.

Signature: _____ Date: _____

Physically I'D ☐ Y ☐ N

Google Review



Yelp Review

