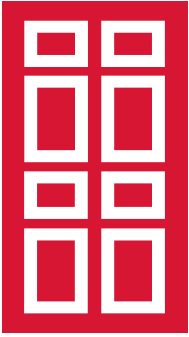


Guest Pre-Treatment Form



name: _____ M F date: _____
Month / Day / Year

street address: _____ apt #: _____ city: _____

state: _____ zip: _____ home: _____ cell: _____

e-mail address: _____ date of birth: _____
Month / Day

Please check here if you DO NOT wish to receive e-mails regarding what's new, special offers or latest beauty news.

The following information is needed to ensure your comfort and well-being as a guest of Red Door. Additional information about the relevance of these questions is available upon request. We may ask you to update your record from time to time. We have taken measures to ensure the security and confidentiality of the information contained on this document.

1. Please check any of the conditions below that are currently applicable.

- | | | |
|---|--|---|
| <input type="checkbox"/> allergies* (eg. lanolin, latex, nuts, seaweed) | <input type="checkbox"/> epilepsy | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> fever | <input type="checkbox"/> recent scar tissue |
| <input type="checkbox"/> asthma | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> rosacea / sensitive skin |
| <input type="checkbox"/> back/neck problem | <input type="checkbox"/> fungal disease | <input type="checkbox"/> skin disorder |
| <input type="checkbox"/> bruises/broken capillaries | <input type="checkbox"/> heart condition/pacemaker | <input type="checkbox"/> sunburn |
| <input type="checkbox"/> cancer* | <input type="checkbox"/> heat sensitivity | <input type="checkbox"/> thrombosis |
| <input type="checkbox"/> cold sores/herpes | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> thyroid problem |
| <input type="checkbox"/> contagious condition/disease* | <input type="checkbox"/> metal pins/plates | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> claustrophobia | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> other* |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> open wounds | |

*Please provide additional information: _____

2. Are you currently pregnant or undergoing fertility treatments? Yes No
3. Are you currently taking any prescription medications? Yes No (please list) _____

4. Are you currently or have you within the past six months used/taken Avage, Avita, Differin/Accutane, Metrogel, Renova, Retin A, or Tazorac? Yes No (please list) _____
5. Have you had any advanced skincare treatments in the past two weeks? Yes No
6. Are you wearing contact lenses? Yes No

I confirm that, to the best of my knowledge, the answers above are correct, and I have not withheld any relevant information. I hereby agree to assume all risk and responsibility and to hold the Spa and its employees harmless in the event I sustain any injury or damage to my person, directly or indirectly, as a result of my receiving services, and I further agree to release the Spa and its employees from any claim, cause of action, suit, damages, etc. that may result from any such injury or damage.

PLEASE NOTE: We regret that we cannot be responsible for the loss or damage of personal articles. Please keep all valuables with you during your services.

print name: _____ signature: _____ date: _____

FOR INTERNAL USE ONLY

Technician comments: _____

Face/Wax _____ Body _____ Nail _____ Hair _____