

Client Information and Consent: Body Treatments

Please print clearly.



First Name _____ Last Name _____ (Circle One: Dr / Mr / Mrs / Ms)

Address _____

City _____ State _____ Zip _____

Day Telephone _____ Evening Telephone _____

Email _____ Date of Birth _____

Occupation _____ Referred By _____

In case of emergency, contact: _____
Name _____ Phone _____

Are you a member of the Wilfred R. Cameron Wellness Center? Yes No

How did you hear about Spa Harmony? _____

Are you interested in receiving lifestyle recommendations, i.e., exercise, sleep and general health suggestions? Yes No

We may use mailing information for internal business or marketing purposes.

THE WELLNESS SPA AT THE
WILFRED R. CAMERON WELLNESS CENTER
OF THE WASHINGTON HOSPITAL

240 Wellness Way
Washington, PA 15301-9697
724.250.5238
www.spaharmony.org

Please check appropriate box and make comments as necessary.			
	YES	NO	COMMENTS
1. Have you ever had a professional massage and/or bodywork treatment?			
2. Are you currently under a physician's care?			
3. Physician's Name/Phone #			
4. Have you had surgery within the last 5 years?			
5. Have you had an injury lately?			
6. Are you taking any medications?			
7. Do you have:			
Infectious disease			
Heart trouble			
High/Low blood pressure			
Diabetes			
Arthritis/Bursitis			
Blood clots			
Phlebitis			
Cancer			
Nervous tension/headaches			
Spinal problems			
Seizure disorder			
Varicose veins			
Skin problems			
Digestive disorders			
Sleep disorders			
Numbness or tingling sensation in any limb (including hands and feet)			
8. Are you allergic to lotions, oils, scents, nuts?			
9. What are your daily physical activities? Please include work activities as well as exercise.			
10. Are you pregnant? If yes, how many weeks? _____			
11. Are you wearing contact lenses?			
12. How much water do you consume daily?			

OVER

