

Spa Client History

Please print clearly.



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

Address _____

City _____ State _____ Zip _____

Day Telephone _____ Evening Telephone _____

Email _____ Date of Birth _____

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

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

Were you referred by a dermatologist? Yes No If yes, please list name: _____

How did you hear about Spa Harmony? (Circle all that apply.)

Observer/Reporter Member Direct Mail Friend Redeeming a Gift Card Yellow Pages Web Site Other _____

Are you a member of the Wilfred R. Cameron Wellness Center? Yes No *We may use mailing information for internal business or marketing purposes.*

Do you have any health issues? (Check all that apply.)

- Heart/Cardiovascular
- Diabetes
- Hormonal Problems
- Skin Cancer
- Thyroid (over or under active)
- High/Low Blood Pressure
- Allergies (please list all, including seafood) _____

Other Conditions _____

Please list any medications you take, including birth control: _____

Have you taken any blood thinners, aspirin or any anti-coagulant within the past 24 hours? Yes No

Are you pregnant? Yes No

Any recent surgery or dermabrasion? Yes No
If so, please list: _____

Have you been treated by a dermatologist? Yes No
If so, for what conditions? _____

Do you use products that contain Isotretinoin Yes No

Retin A Yes No

Tetracycline Yes No

AHA (Alpha Hydroxy Acid)/Glycolic Acid Yes No

Hydroquinone Yes No

Accutane Yes No

Do you have implants? (Pacemaker, hip replacement, etc.) Yes No
If so, please list: _____

Are you wearing contact lenses? Yes No

Facials

Have you ever had a facial before? Yes No

Have you ever had an adverse reaction to a cosmetic product? Yes No

If so, which product or ingredient caused the reaction? _____

Have you recently had any type of chemical or glycolic peel? Yes No

If glycolic, what percentage? _____

If chemical, please explain _____

Waxing/Sugaring

Have you ever had a wax/sugar treatment? Yes No

If yes, list areas: _____

Any problems? Yes No

Do you have any moles, warts, abrasions, skin irritations or skin inflammations in the areas to be waxed/sugared? Yes No

Have you been exposed to any tanning method in the past 24 hours? Yes No

In an effort to make your waxing experience as comfortable as possible, please supply your technician with all the necessary details in regard to past waxing/sugaring procedures or health information not requested on this form. _____

Waxing Release

I understand that the waxing/sugaring service I have requested involves the application of heated products that may cause an adverse reaction to my hair, skin or body on which the service is performed. I hereby release this establishment, its agents and suppliers from any and all damage or injury that may result from the treatment I requested. Initial _____

OVER

Skincare Regimen:

What products are you currently using to cleanse your face?

What products are you currently using to moisturize?

Are you using any other special products? (eye cream, night cream, masks)

What benefits are you looking for?

Please read and sign the following:

I understand that the health information that I have provided will be used in a manner consistent with the Notice of Privacy Practices at The Washington Hospital. (Privacy Notice). I have been offered the opportunity to read the Privacy Notice.

Client Signature

Date

Consent for Minor

I, _____ am the parent or legal guardian of _____. I am aware that my
(parent or guardian name) (name of minor)
child is receiving spa services by _____ for the purposes listed here: (example: facials, sugaring, waxing, etc.)
(name of technician)

I understand that spa services are not intended to be or replace medical advice or medical treatment, and that I should consult with my child's primary care provider if I have any concern or questions about the appropriateness of any treatment.

Signature of Parent/Guardian _____ Date _____