Waterford

Client Analysis

Today's Date ____________ Name______________________________
Date of Birth ___________
Address___________________City____________State____Zip _____
Phone (home)__________(work)_____________(cell)_____________
Email_________________________Occupation __________________

To help our consultants determine your needs, please answer as honestly and completely as possible. ALL INFORMATION WILL BE KEPT PRIVATE AND CONFIDENTIAL.

MEDICAL HISTORY: Please circle if you have ever had or currently have:
Diabetes, Cancer, Kidney Disease, Liver Disease, Shortness of Breath, Anemia, Heart Murmur, Heart Condition (Heart Attacks/Chest Pain), Stroke, Blood Clots, Asthma,
Fever Blisters, Plastic Surgery within the past 6months, Contact Lens, Eye Disease, Glaucoma, Hepatitis, HIV, Seizure Disorder, High Blood Pressure, Headaches, Hormone Imbalance, Hysterectomy, Arthritis or Joint Disorders, Spinal/Neck Problems, Insomnia
Additional conditions: ____

Allergies? (Circle all that apply) Medications, Aspirin, Antibiotics, Lidocaine, Talc, Latex, Fragrances, Retin-A, Hydroquinone, Alpha or Beta Hydroxy Acids,
Hydrogen Peroxide, Hydrocortisone, Benadryl, Plant or Fruit Derivatives,
List other Allergies____
Have you ever used a product that caused a reaction? Yes No
Over the counter meds: ____
Primary Physician____
Current prescription medications:______________________________________
Pharmacy of choice: ____
List any surgeries in the last 12 months ___________________________________
Dermatologist that you see regularly or in the past___________________________

Muscular/Skeletal Concerns
Have you had a professional massage before? Yes No
Areas of complaint, pain, or tension _____________________________________
Have you had any broken bones in the past 2 years? Yes No
Do you have numbness or stabbing pains anywhere? Yes No
Do you suffer from frequent or recurrent leg cramps? Yes No
Are you sensitive to touch/pressure in any area? Yes No
If Yes, where? ____
*Massage therapy is not a substitute for medical treatment or diagnosis. We recommend that you see a physician for any ailment you may have. Massage therapists do not prescribe medical treatments, pharmaceuticals, or perform spinal adjustments.

Skin Condition/Concerns
Oil Secretion
Do you experience breakthrough oily shine during the day? Yes No
Are you presently using Retin-A or any type of acid? Yes No

Do you experience skin breakouts? Yes No
If yes, what medications do you use to control breakouts? ___________________________
Are you on Accutane or completed a course within the past six months? Yes No

Pigmentation Problems

Do you have blotchy skin (melasma or brown spots)? Yes No
How long have you had this condition? _______

Sun Exposure

Do you sunbathe? Yes No If yes, which? Tanning Booths or Natural Sun
Do you use a sunscreen daily? Yes No
If Yes, What SPF? _______ How Often? Daily Occasionally Rarely
What results are you looking to achieve with your skin?
____
What skin products are you currently using?
____

For Female Clients Only:

Could you be pregnant? Yes No Are you trying to become pregnant? Yes No
Are you taking hormone therapy? Yes No
Are you taking, or have you taken birth control pills? Yes No

I would like more information on the following treatments: (circle all that apply)

Spider Veins Mole/Lesion(s) Wrinkle Fillers Botox Skin/Tissue Tightening
Tattoo Removal Hair Reduction Laser Skin Rejuvenation Waxing/Hair Removal
Body Wraps/Polish Massage Facials/Skin Care Lash Perms/Dyes Peels
Bare Minerals Make-Up Nail Care Ion Body Detox Sunless Tanning

Please read carefully and sign prior to treatment:

To the best of my knowledge the information I have provided is complete and correct.
The proposed treatment has been satisfactorily explained to me and I have all the information which I desire. I will not hold liable The Waterford Wellness Spa for complications or reactions including but not limited to: abrasions, tears, breakouts, burns, bruising, discoloration, infection, irritation or allergic reactions resulting from any of the following spa treatments: Massage, Waxing, Perms/Dyes, Facials, Chemical Peels, Manicures, Pedicures, Body Polishes or Wraps, Sunless Tanning & Ion Body Detox

I hereby give my consent, authorization and voluntarily release to all persons working at The Waterford Wellness Spa from all claims that have or may in the future have a connection to any treatment in this office.

Cosmetic, Laser or Medical Treatments offered require a separate signed consent.

Patient Signature ___________________________________

Technician Signature _________________________________