



Skin Care Treatment Client Information & Consent Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Birthdate: _____ Occupation: _____

How did you hear about Spa Western? _____

Emergency Contact (Name, Relationship, Phone Number): _____

What would you like to achieve from your skin care treatment today? _____

What were your favorite things about past skin care treatments? _____

What are your least favorite things about past skin care treatments? _____

Spa Western Skin Care Treatment Guidelines

Your skin care therapist will need an updated list of medications, supplements, allergies and sensitivities, as well as any relevant medical history changes since your initial consultation in order to ensure you receive the best treatment. Any changes to this list without the skin therapist being aware can affect how your skin reacts to treatments and your home care.

Your skin care therapist will adjust your home care routine on a regular basis to keep your skin progress moving forward. If your home care routine is not changed often enough, your skin will adapt to the regimen and stop responding. In other words, you won't progress and reach your goals.

Due to expensive spa equipment and skin care products in our treatment rooms that can be dangerous to children, we ask you make arrangements for your children during your service. We have childcare available for members & spa guests who want to utilize spa services. Please call at least 24 hours in advance to reserve your child's spot in our childcare.

If you are more than 15 minutes late for your appointment, your skin care therapist does not guarantee you will be seen. If you do not show up for you appointment on multiple occasions, the skin care therapist has the right to charge you for your scheduled service.

Please leave your cell phone on silent or turned off during treatment so it is not a distraction to you or your skin care therapist. If your phone must be on for a specific reason, please let your skin care therapist know at the beginning of the treatment.



Skin Care History

Have you ever received the following skin care treatments before?

Facial Treatment _____ Yes _____ No When? _____

Chemical Peel _____ Yes _____ No When? _____

Dermaplaning _____ Yes _____ No When? _____

Body Treatment _____ Yes _____ No When? _____

Which of the following most closely describes your skin type? Please check the box that describes you.

- | | | |
|--------------------------|---------------------------|----------------------------------|
| <input type="checkbox"/> | 1. Creamy Complexion | Always burns easily, never tans |
| <input type="checkbox"/> | 2. Light Complexion | Always burns, may tan slightly |
| <input type="checkbox"/> | 3. Light/Matte Complexion | Burns moderately, tans gradually |
| <input type="checkbox"/> | 4. Matte Complexion | Seldom burns, always tans well |
| <input type="checkbox"/> | 5. Brown Complexion | Rarely burns, deep tan |
| <input type="checkbox"/> | 6. Black Complexion | Never burns, deeply pigmented |

Please circle any areas of concern you have regarding your skin:

- | | | |
|-----------------------|---------------------------|---------------------|
| Breakouts/Acne | Blackheads/Whiteheads | Excessive oil/shine |
| Rosacea | Broken capillaries | Redness/Ruddiness |
| Sun spots/Brown spots | Uneven skin tone | Sun damage |
| Wrinkles | Dull/Dry skin | Flaky skin |
| Dehydrated skin | Sensitive/Sensitized skin | Fine lines |
| Dark circles | Puffiness | |



Please check the box if you have or have had any of these health conditions:

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Metal bone pins or plates |
| <input type="checkbox"/> Any active infection | <input type="checkbox"/> Headaches (chronic) | <input type="checkbox"/> Phlebitis, blood clots, poor circulation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Psychological treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Blood clotting abnormalities | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Skin lesions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Spinal injury |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Systemic disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Keloid scarring | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Lupus | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Frequent cold sores | | |

Other active dermatological disorders: _____

Do you smoke? Yes No

Do you follow a restricted diet? Yes No Explain: _____

List your daily consumption of: _____ Water _____ Caffeine _____ Alcohol

Do you follow a regular exercise program? Yes No

What is your stress level? High Medium Low

Do you experience any sleeping problems? Yes No

How many hours do you typically sleep each night? _____

Do you wear contact lenses? Yes No

Do you have any metal implants or use a pacemaker? Yes No

Have you experienced claustrophobia? Yes No

Do you suffer from sinus problems? Yes No



List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:

Are you taking any hormonal contraceptives? Yes No

Are you pregnant or trying to become pregnant? Yes No

Are you experiencing any problems related to menopause? Yes No

Are you undergoing any hormone replacement therapy? Yes No

I understand, have read and completed this questionnaire truthfully. I understand that withholding information from my skin care therapist may result in contraindications or skin irritation from treatments received at Spa Western. The skin care treatments I receive at Spa Western are voluntary and I release Spa Western and their employees from liability and assume full responsibility thereof.

Printed Name	Signature	Date
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For guests under the age of 18:

As the parent or legal guardian of _____ (minor's name), I give permission for her/him to have spa services performed at Spa Western. I confirm that I have read and understand all information on the applicable forms for this treatment or service, and accept responsibility on my child's behalf for any disclosures or liabilities described on these forms. I agree to supervise any home care procedures that are recommended as a result of the treatment.

Full name of parent or guardian	Signature of parent or guardian	Signature of Skin Care Therapist	Date
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Signature of WRFC employee
(f Skin Care Therapist is not available)

This form must be signed in person by the parent or guardian at the time of the service or before the service, witnessed by the skin care therapist or another Western Racquet and Fitness Club employee.