RESET

MEDICAL Spa AT WATSON CLINIC LLP

PERSONAL CARE GUIDE

Welcome to our Spa!

Thank you for taking the time to complete this Personal Care Guide. Your responses to these questions will help us to serve you better. We hope you enjoy your time with us today.

Bella Vista Building • 1755 N. Florida Ave. • Lakeland, FL 33805 • Office: 863-904-6250 • Fax: 863-904-6254 • www.WatsonClinic.com

Hours: Monday, Wednesday and Friday: 9 am - 6 pm • Tuesday and Thursday: 9 am - 8 pm • Saturday: 9 am - 2 pm

GUEST INFORMATION

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Email: _____

Preferred Method of Confirmations: ☐ Home ☐ Cell May we contact you concerning specials via your e-mail address? ☐ Yes ☐ No

Emergency Contact Information:

Name: _____ Phone: _____

List current medications and purpose ie: Coumadin, *(please include hormones, vitamins and any herbal supplements)* _____

Do you have any allergies, including one to any medications? ☐ Yes ☐ No If yes, please list: _____

Are you taking Accutane or any other acne medications? ☐ Yes ☐ No If yes, for how long? _____

Do you use any glycolic products? ☐ Yes ☐ No

Do you use Retin A, Renova, other topical vitamin A or hydroquinone? ☐ Yes ☐ No If yes, for how long? _____

PRESENT HEALTH CONDITIONS *Please check any of the following that you now have or have had.*

Musculoskeletal ☐ Bone or joint disease/Broken bones ☐ Tendonitis/Bursitis ☐ Jaw Pain (TMJ) ☐ Spinal problems
☐ Arthritis/Gout/Lupus/Fibromyalgia ☐ Osteoporosis ☐ Spinal problems ☐ Sciatica ☐ Other: _____

Skin ☐ Easy bruising ☐ Rashes ☐ Athletes foot ☐ Vitiligo ☐ Herpes/cold sores/fever blisters
Areas of Inflammation: _____ Other: _____

Nervous System ☐ Shingles ☐ Numbness/Tingling ☐ Multiple Sclerosis Pinched Nerve/Nerve Degeneration
☐ Seizures/Convulsions Other: _____

Circulatory ☐ Heart Condition ☐ Blood Clots ☐ Phlebitis/Varicose Veins ☐ High/Low Blood Pressure
☐ Thrombosis/Embolism Other: _____

Digestive ☐ Irritable Bowel Syndrome ☐ Ulcers ☐ Other: _____

Reproductive System ☐ Pregnant? # of week _____ ☐ Ovarian/Menstrual Problems Date of last period _____
☐ Prostate issues ☐ Other: _____

Respiratory ☐ Breathing Difficulty/Asthma ☐ Allergies ☐ Emphysema ☐ Sinus ☐ Other: _____

Other ☐ Cancer/Tumors ☐ Bladder/Kidney Ailment ☐ Diabetes ☐ Drug/Alcohol/Caffeine/Tobacco use ☐ Chronic Fatigue
☐ Chronic Pain ☐ Sleep Disorders ☐ Migraines/Headaches ☐ Anxiety/Stress Syndrome ☐ Depression
☐ Contact lenses (hard or soft) ☐ Infectious disease ☐ Surgeries ☐ Other: _____

WAIVER

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage bodywork or esthetic treatments may not be recommended. A referral from your primary care physician may be required prior to service being provided.

I understand that massage, body work, facials and nail services are provided for the basic purpose of relaxation, beauty and/or relief of muscular tension. If I experience any discomfort during this session, I will immediately inform the practitioner so that the product, pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or body work should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician for any mental or physical ailment that I am aware of. I understand that the practitioners are not qualified to perform spinal or skeletal adjustments, diagnose or prescribe. I affirm that I have stated my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and I understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances may be considered sexual harassment and will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized and I will be charged for the originally booked service. I am aware that I may be charged for any missed appointments that I do not give 24 hour notice to cancel or reschedule.

Client Signature: _____

Please complete this section if you are receiving a massage or body treatment today:

Massage History and Session Information: *Please check as many answers that apply.*

Have you ever received a professional massage: ☐ Yes ☐ No If yes, date of last massage:_____

My goal for my massage today is: _____

Have you had any injuries/accidents/illnesses still affecting you? ☐ Yes ☐ No If yes, please describe: _____

I feel the pressure that would best fit my needs would be: ☐ Light ☐ Medium ☐ Deep/Heavy ☐ I don't know

The therapist will always work within your tolerance level. It is your responsibility to tell him/her if the pressure is/isn't correct for you.

Please indicate any area of tension or soreness that you would like the massage therapist to address specifically. _____

Prioritize ONLY specific problem area: (1 – High Priority, 2 – Secondary, 3 – If we have time)

___Neck ___Upper Back ___Lower Back ___Legs ___Arms ___Hand Feet ___Hip ___Face/Scalp ___Upper Chest

SKIN CARE AND WAXING HISTORY AND SESSION INFORMATION *(Please complete this section if you are receiving a facial service or waxing today.)*

Have you been seen by a dermatologist or cosmetic/plastic surgeon? ☐ Yes ☐ No If yes, for what reason? _____

For our female guests: Are you pregnant or lactating? ☐ Yes ☐ No

Have you had any of the following procedures? Laser resurfacing: ☐ Yes ☐ No If yes, date:_____

Light chemical peel: ☐ Yes ☐ No If yes, date:_____

Medium/Heavy chemical peel: ☐ Yes ☐ No If yes, date:_____

Microdermabrasion: ☐ Yes ☐ No If yes, date:_____

Do you ever experience tightness or flaking of your skin? ☐ Yes ☐ No

Do you tan or frequent tanning booths? ☐ Yes ☐ No

Do you have a history of fever blisters or cold sores? ☐ Yes ☐ No

What are your expectations of the skin care treatment you will receive today?_____

_____

Which concerns apply to you? *(Please check all that apply.)*

☐ Brown Spots (Hyperpigmentation) ☐ White Spots (Hypopigmentation) ☐ Visible exposed blood vessels ☐ Clogged pores ☐ Enlarged pores ☐ Excessive Oiliness ☐ Dry patches ☐ Uneven Skin Tone ☐ Blackheads/Whiteheads ☐ Hard bumps under skin ☐ Scarring ☐ Acne ☐ Unwanted Hair ☐ Skin Laxity ☐ Upper lip lines ☐ Wrinkles ☐ Other: _____

What is your skin type? ☐ Normal ☐ Dry ☐ Oily ☐ Combination

Please check the products you currently use and list the Brand Names of Cosmetic Products:

☐ Facial Cleanser _____

☐ Scrub _____ ☐ Toner _____ ☐ Moisturizer _____

☐ Anti-aging Serum _____ ☐ Growth Factors _____ ☐ Sunscreen _____

☐ Retinol_____ ☐ Eye Cream_____ ☐ Antioxidant _____

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? ☐ Yes ☐ No

If yes, please list:_____

Are you interested in a skin care regimen? ☐ Yes ☐ No

Have you ever had any of the following injectables or implants: ☐ Botox ☐ Juvederm ☐ Radiesse ☐ Restylane ☐ Perlane

☐ Silicone ☐ Hylaform ☐ Collagen ☐ Artefill ☐ Lipo Dissolve ☐ Other: _____

If so, when was it done? _____ What area? _____

Do you have any of the following chronic skin disorders? ☐ Psoriasis ☐ Dermatitis ☐ Eczema ☐ Keloid Scarring ☐ Sun Blisters

Are you currently removing unwanted hair by any of the following methods? ☐ Waxing ☐ Tweezing ☐ Electrolysis ☐ Laser

☐ Depilatory products (ie: Nair) If so , when was the your last hair removal?_____ What area?_____

If you had Laser Hair Removal, what type of laser? _____

RELEASE FORM FOR HAIR REMOVAL: I AM presently using:

☐ Retin A or any other topical vitamin A ☐ any exfoliant or hydroxyl-based products ☐ Accutane or any other acne medication ☐ any medications such as cortisone, blood thinners, or diabetic medication

I understand that if I begin using any of the above products and do not inform my esthetician/cosmetologist prior to hair removal, I am accepting full responsibility for any skin reactions.

_____ Date:_____ _____ Date:_____

Client Signature: Technician Signature: