Name: ____ Date: ______________________

Address: ____

City: ____ State: __________ Zip: _____________

Date of Birth: ________________ Age: _________ Occupation: ___________________________

Home Phone: ______________ Business Phone: ______________ Cell Phone: ________________

E-mail: ____

In case of Emergency, Please Contact: ____

Phone number: _________________ Relationship: _______________________________________

How did you hear about us? Internet Facebook Billboard Friend/Relative Other:

Please Specify: ____

Your Health Information:

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?

No _____ Yes _____ Explain: ____

2) Any recent surgery, including plastic surgery? (past 12 months) No _____ Yes _____ Explain: __________

____

3) Any skin cancer? No _____ Yes _____ Explain: ____

4) Have you had any piercings, tattoos, or permanent cosmetics? No _____ Yes _____ If yes, where?

____

5) Have you ever had a body spa treatment before? No ____ Yes ____ If yes, What and When? _________________

6) Has your physician discussed concerns about raising your body temperature? No _____ Yes _____

Explain: ____

Confidential Client Health History Form (select all that apply and provide additional information in the space provided on page 3)

_____ Cancer
_____ Hormone Imbalance
_____ Systemic Disease
_____ High Blood Pressure
_____ Spinal Injury
_____ Thyroid Condition
_____ Hysterectomy
_____ Diabetes
_____ Heart Problem
_____ Varicose Veins
_____ Arthritis
_____ Asthma
_____ Eczema
_____ Epilepsy
_____ Seizure Disorder
_____ Fever Blisters
_____ Headaches (Chronic)
_____ Hepatitis
_____ Herpes
_____ Frequent Cold Sores
_____ Immune Disorders
_____ Ulcers
_____ HIV/Aids
_____ Lupus
_____ Metal bone pins or plates
_____ Prenancy, if yes number ofweeks ____

7) Do you smoke? No _____ Yes _____

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

9) Have you had anything to eat today? No _____ Yes _____Explain: _________________________________

10) Do you follow a regular exercise program? No _____ Yes _____

11) What is your stress level? High _____ Medium _____ Low _____

12) List any medications you take regularly: ____

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

14) Do you have any metal implants or wear a pacemaker? No _____ Yes _____

15) Do you use any of the following? Retin-A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA, Salicylic Acid or Retinol/Vitamin A derivative products? No ____ Yes ____ Explain: ________________________

16) Have you used any of these products above in the last 3 months? No _____ Yes _____

17) Have you used an acne medication? (Such as Accutane or Isotretinoin) No ___ Yes ___ Which Drug: _____________

18) Do you form thick or raised scars from cuts or burns? No _____ Yes _____

19) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? No _____ Yes _____ Describe: ____

20) List your daily consumption of: Water ____________ Caffeine ___________ Alcohol ______________

21) Do you wear contact lenses? No _____ Yes _____

22) Have you been exposed to the sun or tanning bed in the last 48 hours? No _____ Yes _____

23) Have you received a spray tan in the past 7 days? No _____ Yes _____

24) How frequently are you exposed to the sun or tanning bed? ____ Infrequently ____ Frequently ____ Regularly

25) Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

26) Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs

Fragrance Shellfish Latex Drugs Other: ____

If yes, please explain: ____

27) In the last six months have you had:

_____ A Chemical Peel
_____ Laser Treatment
_____ Facial Injections or Fillers
_____ Infection
_____ Skin Rashes/Skin Disorders
_____ Imflammation
_____ Blood Thinners
_____ Circulatory/Heart Problems
_____ Phlebitis/Blood Disorder
_____ Recent Injury or Trauma
_____ Stroke
_____ Acute Joint/Muscle Injury
_____ Abdominal/Inguinal Hernia
_____ Open Cuts/Bruises/Burns
_____ Lipoma/Angioma
_____ Dizziness
_____ Corticosteroid Treatments
_____ Raises Moles

If you answered yes to any of the above please explain: ____

____

I understand and have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the service providers of my current medical or health conditions and to update this history. The treatments received here are voluntary and I release this institution and/or service providers from liability and assume full responsibility thereof.

Client Signature: ____ Date: ______________________

Female Clients Only:

28) Are you currently taking any oral contraceptives? No _____ Yes _____ Specify: ________________________

29) Are you pregnant or trying to become pregnant? No _____ Yes____ If yes, please list any complications below

30) Are you lactating? No _____ Yes _____

31) Any menopause problems? No _____ Yes _____ Specify: _______________________________________

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

____

____

____

Client Signature: ____ Date: _____________________

Hydrotherapy/ Steam Room Consent for Treatment

I, ________________________________, hereby consent to the performance of a Hydrotherapy/Steam Room treatment for myself.

I understand that these services are NOT SAFE for a pregnant woman and their unborn child. I am not pregnant or trying to become pregnant at this time.

I understand that these services may NOT be combined in the same 24-hour period.

I understand that methods or treatments may include, but are not limited to Hydrotherapy Bath, Aromatherapy Steams, and or Shower treatments.

Hydrotherapy attempts to normalize physiological functions, to modify the perception of pain, and to treat dysfunction of the body. I have been informed of the following possible side effects:

elevated body temperature
dehydration
headaches
dizziness/ vagal response /fainting
fatigue
aggravation of current condition
nausea
vomiting
diarrhea
ringing in the ears
vision changes

I do not expect Spa Greystone to be able to anticipate all risks and complications.

I do not expect Spa Greystone to diagnose or treat any disease. I wish to rely on the Spa Greystone Staff to exercise their judgment during the course of the procedure in my best interests.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of the hydrotherapy treatment.

By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment:

_______________________________________ _______________

Client's Name Date

____

Client's Signature

FINANCIAL AND CANCELLATION POLICIES

Cancellation and No-Show Policy: Time with a service provider is blocked on our schedule for your appointment. We are happy to reschedule all treatments or appointments that are cancelled with advance notice of at least 24 hours. Clients who do not show up for a scheduled treatment or appointment, or who cancel without this notice, will be charged 50% of the total services scheduled that day as a cancellation fee. This will be automatically charged to the credit card we have on file. If we do not have a current credit card on file, the amount will be added to the account balance and must be paid before any additional services are scheduled.

Product Refunds: We cannot offer a refund on skincare or other products that have been opened or that are returned unopened more than thirty days after their purchase. We are happy to give you samples of products to try prior to your purchase of a product.

Credit for Unused Services: If a client does not tolerate a procedure, we will be happy to offer credit for alternate services equal in value to the services that have been purchased. No cash refunds can be given on unused services and credit for services cannot be used to purchase products. We make no guarantee as to the final result for client's treatments and we do want to make clients aware that our recommendations regarding number of treatments are only an estimate and to achieve optimal results, additional treatments may be needed. Any unused funds left on patient/client account will be forfeited two years from date of deposit.

Pre-treatment Instructions: We reserve the right to cancel and/or reschedule procedures if a client has not followed our pre-treatment instructions (e.g., sun tanning before a laser treatment) and to charge the cancellation fee. This policy is to ensure that our clients have the best possible outcomes from their treatments and reduce the risk of an adverse result.

I have read and understand this Financial and Cancellation Policy for Spa Greystone and agree to comply with this policy.

Date: ______________________________

Client Name (please print): ____

Client Signature: ____

Photography Consent

Consent to take and for the release of Photographs/Slides/Videotapes/Medical Records

I hereby authorize Hedden Plastic Surgery and/or Spa Greystone to use all photos including but not limited to pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, internet, social media sites (Instagram, Facebook, YouTube, Snapchat, etc.), and websites for purposes of medical education, specialty board certification, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to any monetary payment or any other consideration as a result of any of the images and/or my interview. I also consent for my medical record to be released to a peer physician when necessary for peer chart review.

Signature: ___________________________ Date: ____________________