Initial Confidential Consultation & Health History

Date: ________________________

We care about providing you with the best care so please review and answer the questions on this form so we can give you a thorough consultation and prevent against any contraindications.

Name: ____ Date of Birth: ____________________

Address: ____zip________________

Home Phone: _______________________________ Business Phone: ______________________________

Cell Phone: ______________________ E-mail address: ____

(email address will be used for appointment reminders and our specials email list)___check here if you do not want to be on our email list

Single: _______ Married: ________ If married, anniversary date: ___________________

Employer: ___________________________________ Occupation: _________________________________

Does your job require that you work outdoors? _______ No _______ Yes

How did you hear about us? ____

If you were referred, by whom?____(Every guest you send us you get $10)

Your Skin

1) Do you have any special skin problems or concerns pertaining to your face or body? _____ No _____ Yes

If yes, please explain:____

2) Have you ever had a facial treatment before?_______ No _______ Yes

If yes, what type and when? ____

3) Have you ever had a Massage before?_______ No _______ Yes

If yes, what type and when? ____

4) Have you ever had chemical peels, laser or microdermabrasion? _____ No ______Yes

If yes, what and how long ago? ____

5) Have you ever or do you currently use Deferin, Glycolic Acid, Salicylic Acid, Accutane, Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? _______ No _______Yes

If yes, please explain which and how long? ____

6) Have you used or do you currently use a prescription acne medication? _______ No _______Yes

If yes, which drug? ____

7) What skin care products are you currently using? (List brand where known)

Facial Cleanser ____________________________ Shampoo/conditioner____________________

Toner __________________________________ Body Lotion ___________________________

Mask ___________________________________ Eye Product ___________________________

Night Moisturizer _________________________ Day Moisturizer ________________________

Exfoliator/scrub___________________________ Lip treatment____________________________

Foundation ______________________________ Sunscreen ______________________________

SPF _____ How often? _______________

8) Have you recently used any self-tanning lotions, creams or treatments? _______ No _______Yes

If yes, please explain: ____

9) How frequently are you exposed to the sun or use a tanning bed?

_________Infrequently _________Frequently _________Regularly

10) Have you used any of the following hair removal methods in the past six weeks? Circle all that apply.

Shaving Waxing Electrolysis Tweezing Threading Depilatories

11) What areas of concern do you have regarding your:

Skin: (Please check any that apply)

_____ Breakouts
_____ Blackheads/Whiteheads
_____ Excessive oil/shine
_____ Rosacea
_____ Broken capillaries
_____ Redness/ruddiness
_____ Psoriasis
_____ Uneven skin tone
_____ Sun damage
_____ Fine lines/wrinkles
_____ Dull/dry skin
_____ Sun spots/brown spots
_____ Eczema
Other ____________________

Eyes: dry ____ fine lines/wrinkles ____ puffiness ____ dark circles _____ Other: ______________

Lips: dry _____ cracked/chapped ______ Other: ______________

12) Have you ever had an allergic reaction to any of the following?

_____ Cosmetics
_____ Medicine
_____ Food
_____ Animals
_____ Sunscreens
_____ Iodine
_____ Pollen
_____ AHAs
_____ Fragrance
_____ Shellfish
_____ Latex
_____ Drugs
Other ______________________

If so, please explain:____

____

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

Rash Irritation Peeling Sun Sensitivity Breakout

14) Have you experienced Botox, Restylane or Collagen injections in the last 72 hours?

______ No ______Yes If yes, please explain: ____

15) Do you form thick or raised scars from cuts or burns? _____ No _____Yes

16) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? _____ No _____Yes

If yes, please explain: ____

17) What is your daily consumption of (in ounces)

Water ______________________ Caffeine ____________________ Alcohol ___________________

Your Health

---

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year? _______ No _______Yes

If yes, please explain: ____

2) Any recent surgery, including plastic surgery? _______ No _______Yes

If yes, please explain: ____

3) Any skin cancer? _______ No _______Yes

If yes, where on your person:____

4) Have you had any facial piercings, tattoos, or permanent cosmetics? _______ No _______Yes

If yes, where on your person:____

5) Have you had any of these health conditions in the past or present? (Please check all that apply and provide additional information in the space provided)

______Cancer
______Depression
______Systemic disease
______High blood pressure
______Spinal injury
______Thyroid condition
______Hysterectomy
______Diabetes
______Heart problem
______Varicose veins
______Arthritis
______Asthma
______Epilepsy
______Seizure disorder
______Fever blisters
______ Headaches (chronic)
______ Hepatitis
______ Herpes(contraindication to waxing)
______ Frequent cold sores
______ Immune disorders
______ Lupus
______ Metal bone pins or plates
______ Phlebitis, blood clots, poor circulation
______ Blood clotting abnormalities
______ Psychological treatment
______ Skin diseases/skin lesions
______ Insomnia
______ Keloid scarring
______Recent antibiotic use
______ Any active infection

6) Do you smoke? _____ No _____Yes Live with a smoker? _____ No _____Yes

7) Do you suffer from sinus problems? _____ No _____Yes

8) Do you follow a regular exercise program? _____ No _____Yes

9) Do you wear contact lenses? _____ No _____Yes

10) Do you have any metal implants or wear a pacemaker? _____ No _____Yes

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

12) List any medications or vitamins you take regularly:

____

Female Clients Only:

1) Are you taking oral contraceptives? _____ No _____Yes
2) Are you pregnant or trying to become pregnant? _____ No _____Yes
3) Are you lactating/nursing? _____ No _____Yes
4) Are you experiencing menopause? _____ No _____Yes
   If yes, please explain:____
5) Are you undergoing any hormone replacement therapy? _____ No _____Yes
   If yes, please explain: ____

Male Clients Only:

1) What is your current shaving system? Wet shave _______ Electric _______
2) Do you experience irritation from shaving? _____ No _____Yes   Ingrown hairs? _____ No _____Yes

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

____

____

____

____

Late arrival and Cancellation Policy

Please give at least 24 hour notice for any appointment changes or cancellations. Notices less than 24 hours will result in the full charge of your appointment. Late arrivals will reduce your treatment time so plan to be a few minutes early to enjoy your full treatment time.

Full Disclosure Statement

I understand, 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 my therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or Therapist from liability and assume full responsibility thereof. I understand I will make any changes to this form on future visits if the information has changed.

Client Printed Name: ____

Client Signature: ____ Date:____________________

Client Signature: ____ Date:____________________

Client Signature: ____ Date:____________________

Client Signature: ____ Date:____________________

Client Signature: ____ Date:____________________

Client Signature: ____ Date:____________________

Client Signature: ____ Date:____________________