Confidential Client Health History Form

Date: _____

Name _____ Date of birth: _____

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

Cell Phone: _____ E-mail: _____

Emergency Contact:_____

What services are you interested in ? □ Body Contouring □ Skin tightening

□ Hair removal □ Botox □ Chemincal Peel □ Acne Treatment □Age Spot removal

□ Wrinkle reduction □ Massage □ Nails □ Weight management □ Filler

How did you find us?: :

Your Health

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

☐ No ☐ Yes, explain:_____

2) Any skin cancer? ☐ No ☐ Yes, explain: _____

3) When was your last facial _____ massage _____ or body treatment? _____

Where _____?

4) 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

Please circle of you have any of these issues TODAY)

Cancer ☐
Cuts/Burn/Bruising ☐
Dizziness ☐
Eczema/Psoriasis ☐
Epilepsy/Seizure ☐
disorder ☐
Fever blisters ☐
Heart problem ☐
Varicose veins ☐
Arthritis ☐
Asthma ☐
Hernia ☐
Hormone imbalance ☐
High blood pressure ☐
Spinal injury ☐
Thyroid condition ☐
Hysterectomy ☐
Diabetes ☐

Headaches/ migraines ☐
Hepatitis ☐
Herpes ☐
Cold sores ☐
Immune disorders ☐
HIV/AIDS ☐
Lupus ☐
Metal bone pins or plates ☐
Phlebitis, blood clots, poor circulation ☐
Blood clotting abnormalities ☐
Keloid scarring ☐
Skin disease/skin lesions ☐
Any active infection ☐
Skin rash/poison ivy/irritation ☐
Musculoskeletal problems ☐
Kidney disorder ☐

Confidential Client Health History Form—continued

List any medications you take regularly: _____

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

5) Do you suffer from sinus problems? ☐ No ☐ Yes

6) 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:_____

7) Do you have raised,rough patches (actinic Keratosis) or sun spots on arms, legs or other areas of your body? Yes □ No □

8) Are you Pregnant? Yes □ No □

Facial/Skin Clients:

1) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA , Salicylic Acid or Retinol/Vitamine A derivated products? □ No □Yes, Describe:_____

2) Have you used any of there product in the last 3 months? □No □Yes

3) Have you used an acne medication ? □No □Yes When: _____ Which:_____

4) Do you form tick or raised scars from cuts or burns? □No □Yes

5) Do you Hyperpigmentation (darkening of the skin) or Hypopgmentation (lightening of the skin) or marks after physical Trauma? □No □Yes Describe:_____

6) What has been bothering you about your skin?_____

7) What skin products do you use at home?_____

8) Have you had Botox or filler (Circle wich one)? □No □Yes
   A) When was the last time?_____
   B) Where did you have it done?_____

Massage Clients:

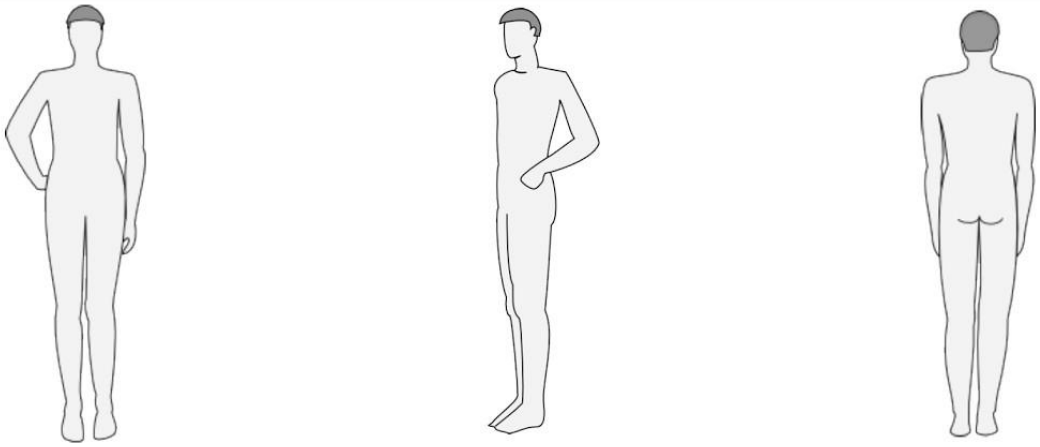
1. What is your major complaint: _____

   _____

2. Goals for your massage therapy today____Relaxation____Rehabiliation
   ____High activity level maintenance

3. Preferred type of touch: ____light/meditative ____heavy/invigorating ___ deep/trigger point

MARK AREAS OF DISCOMFORT



I understand that massage is designed for the purpose of relaxation and relief from tension, muscle spams or poor circulation. The massage therapist cannot diagnose medical issues/disease/disorders or perfome spine palpitations. _____ initial

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 or body from treatments received. I am aware that it is my responsibility to inform the 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 professional from liability and assume full responsibility thereof. I understand the recommendations and suggestions are within the scope of practice of the therapist based on certifications, licenses and education and are not to be considered or to replace medical treatment. In addition, if photos are taken to document treatment progress I give my consent to their use for promotional or advertising and educational purposes without payment or consideration.

Client's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____