In order to submit this form, you should open it with Adobe Acrobat Reader.

Confidential Client Health History Form

Date

Month Day Year

Name

Date Of Birth

Month Day Year

Address

Home Phone

Business Phone

Cell Phone

E mail

example@example.com

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Physician

Phone

Emergency Contact

Phone

Your Health

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

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

Yes,

2 Any recent surgery, including plastic surgery?

☐ No

Yes,

No

Yes, explain

☐ 4 Have you had any piercings, tattoos, or permanent cosmetics? No Yes, If yes, where on your person?

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Yes, explain

☐ 5 Have you ever had a body spa treatment before?NoYes, when:

Yes, explain

Yes,

5) Have you ever had a body spa treatment before?NoYes, when:

Yes, when

6) 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)

Diabetes

☐ Headaches (chronic)
☐ Hepatitis
☐ Herpes
☐ Systemic disease
☐ Frequent cold sores
☐ High blood pressure
☐ Immune disorders
☐ Spinal injury
☐ HIV/AIDS
☐ Thyroid condition
☐ Lupus
☐ Hysterectomy
☐ Metal bone pins or plates

Phlebitis, blood clots, poor circulation

☐ Blood clotting abnormalities
☐ Psychological treatment

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Psychological treatment

- [ ] Insomnia
- [ ] Keloid scarring

Epilepsy

- [ ] Skin disease/skin lesions

Skin disease/skin lesions

- [ ] Any active infection

Seizure disorder

- [ ] Fever blisters

7) Has your physician discussed concerns about raising your body temperature?

No

Yes

explain

No

- [ ] 8 Do you smoke?NoYes
- [ ] Confidential Client Health History Form - -continued

9) Do you follow a restricted diet?No

9) Do you follow a restricted diet? No Yes, specify

10 Do you follow a regular exercise program?

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- [ ] NoYes
- [ ] Medium
- [ ] Low
- [ ] 11 What is your stress level? High

List any medications you take regularly

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

- [ ] 13 Have you used any of these products in the last 3 months?NoYes
- [ ] 12 Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products?NoYes, describe:

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

- [ ] 15 Do you form thick or raised scars from cuts or burns?NoYes
- [ ] Which drug?

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

12) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products?NoYes, describe:

No

Yes, describe

13 Have you used any of these products in the last 3 months?NoYes

- [ ] 14 Have you used an acne medication?NoYes, when?

Yes, when?

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Which drug?

16) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma?NoYes, describe:

No

Yes, describe

List your daily consumption of: Water

Water

Caffeine

Alcohol

Yes 17) Do you experience any problems sleeping?No

No

Yes

18) How many hours do you typically sleep each night?

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Yes 19) Do you wear contact lenses?No

No

Yes

20) Have you been exposed to the sun or used a tanning bed in the last 48 hours? NoYes

Yes

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

- ☐ Infrequently
- ☐ Frequently

Yes 22 Do you have any metal implants or wear a pacemaker?No

- ☐ Yes No
- ☐ 23 Have you ever experienced claustrophobia?

No

Yes

24) Do you suffer from sinus problems?

No

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Yes

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

Animals

AHAs

Drugs

Other

Associated Skin Care Professionals

Confidential Client Health History Form -continued -

If yes, please explain

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Female Clients Only: 27) Are you taking oral contraceptives?No

No

-2-13

Yes, specify

No

No

- [ ] NoYes
- [ ] 28 Any recent changes to or from your contraceptive treatment?

Yes,

so, what and when?

30 Are you lactating?

- [ ] NoYes
- [ ] 29 Are you pregnant or trying to become pregnant?

31 Any menopause problems?

- [ ] No
- [ ] Yes, specify:

specify

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

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 the esthetician/skin care 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 skin care professional from liability and assume full responsibility thereof.

Date

Month Day Year

Associated Skin Care Professionals

The Treatment Room AZ

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