Body Care Treatments Spa

Confidential Health Skin Survey

Client Information Sheet to be filled out PRIOR to each service

Date:_____ Name:_____

Last Name: _____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip: _____

Mobile Phone Number:_____ House Phone Number:_____

Work Phone Number:_____ Occupation:_____

Dermatologist/ PCP:_____ Phone:_____

Emergency Contact:_____ Phone:_____

Name of Esthetician:_____ Tattoo Artist:_____

Have you had a fever or felt feverish recently in the last 14 days? Do you know someone who has?
☐ Yes ☐ No If so, please list when:_____

Are you or someone you are close to having shortness of breath or difficulties breathing?
☐ Yes ☐ No If so, please list when:_____

Have you or someone you are close to experienced a recent loss of taste or smell?
☐ Yes ☐ No If so, please list when:_____

Are you in contact with anyone confirmed COVID-19 positive?
☐ Yes ☐ No If so, please list when:_____

Is this your first facial? ☐ Yes ☐ No

What is the reason for your visit? ☐ Facial ☐ Body

Is your job in the open air? Or do you participate in activities outside for more than 30 minutes? ☐ Yes ☐ No

Are you seeking medical treatment with a doctor for any skin pain or skin problems?
☐ Yes ☐ No If so, please list treatment:_____

Are you pregnant? ☐ Yes ☐ No

Are you taking birth control?
☐ Yes ☐ No If so, please list brand/type:_____

Are you using or have used at some point: Acidos, Accutame, Tazarac, Azelex, Differin, Renova or Retin A acne medication?
☐ Yes ☐ No If so, please list how often and when was the last day that you took it:_____

Do you have acne? ☐ Yes ☐ No

Do you tend to have hyperpigmentation? ☐ Yes ☐ No

Are you allergic to any cosmetics, foods or drugs?
☐ Yes ☐ No If so, please list them:_____

Are you currently taking any oral or topical medications?
☐ Yes ☐ No If so, please list them:_____

Do you use contact lenses? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Are you being treated for stress? ☐ Yes ☐ No

Are you on any hormonal substitution treatment? ☐ Yes ☐ No

Have you ever had skin cancer? ☐ Yes ☐ No

Last date you had any skin fillers done?

Last date you had laser treatment?

What products do you use for your skin regime? Milk cleanser, toner, exfoliant scrub, mask, creams, sunscreen?

Last day you sunbathed or were out in the sun for more than 30 min?

Last date you had Botox?

Please mark if you have any of the following:

☐ Eczema	☐ Hepatitis	☐ Hysterectomy
☐ Chronic headaches	☐ Urinary problems	☐ Any metal implants
☐ Herpes	☐ Lupus	☐ Nasal problems
☐ Fever blister	☐ Pacemakers	☐ Immune disorder
☐ Asthma	☐ Hypertension	☐ Heart problems

Other types of skin disease:_____

Explain the previous problem or other important ones:_____

I understand that the services offered do not substitute any medical treatment and that all information provided by the therapist is for informational purposes only and is not considered prescriptively diagnostic in nature. I understand that the purpose of information here is to assist the therapist in providing a better service and is confidential.

Salon Policies

Before the initial prescription of the products a professional consultation is required. Our active discount rate is valid only for customers that attend the salon every four weeks. We do not make refunds in cash. To cancel a service, a prior notification of 48 hours is required.

Client signature: Date: Name of parent: