Confidential Client Health History Form

Date: _____

Name: _____ Date Of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____E-mail: _____

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? No / Yes If Yes, explain: _____

2) Any recent surgery, including plastic surgery? No / Yes If Yes, Explain: _____

_____

3) Any skin cancer? No / Yes If Yes, explain: _____

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

5) Have you ever had a body spa treatment before? No / Yes If 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)

Cancer	o	Headaches (chronic)	o
Hormone imbalance	o	Hepatitis	o
Systemic disease	o	Herpes	o
High blood pressure	o	Frequent cold sores	o
Spinal injury	o	Immune disorders	o
Thyroid condition	o	HIV/AIDS	o
Hysterectomy	o	Lupus	o
Diabetes	o	Metal bone pins or plates	o
Heart problem	o	Phlebitis, blood clots, poor circulation	o
Varicose veins	o	Blood clotting abnormalities	o
Arthritis	o	Psychological treatment	o
Asthma	o	Insomnia	o
Eczema	o	Keloid scarring	o
Epilepsy	o	Skin disease/skin lesions	o
Seizure disorder	o	Any active infection	o
Fever blisters	o		

7) Has your physician discussed concerns about raising your body temperature? No / Yes
If Yes, explain: _____

_____

Continued ⇨

8) Do you smoke? No / Yes

9) Do you follow a restricted diet? No / Yes If Yes, specify: _____

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

11) What is your stress level? High Medium Low

List any medications you take regularly: _____

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

12) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? No / Yes If Yes, describe: _____
_____

13) Have you used any of these products in the last 3 months? No / Yes

14) Have you used an acne medication? No / Yes When? _____ Which drug?_____

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, describe: _____

List your daily consumption of : Water _____ Caffeine _____ Alcohol _____

17) Do you experience any problems sleeping? No / Yes

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

19) Do you wear contact lenses? No / Yes

20) Have you been exposed to the sun or used a tanning bed in the last 48 hours? No / Yes

21) How frequently are you exposed to the sun or use a tanning bed?
___Infrequently ___Frequently ___Regularly

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

23) Have you ever experienced claustrophobia? No / Yes

24) Do you suffer from sinus problems? No / 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

Continued ⇨

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: _____

Female Clients Only:

27) Are you taking oral contraceptives? No / Yes If Yes, specify: _____

28) Any recent changes to or from your contraceptive treatment? No / Yes If so, what and when? _____

_____

29) Are you pregnant or trying to become pregnant? No / Yes

30) Are you lactating? No / Yes

31) Any menopause problems? No / Yes If Yes, specify: _____

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.

Client Signature: _____ Date:_____