Confidential Client Health History Form

Date: _____

Name: _____ Date Of Birth: _____

Address: _____

Cell Phone: _____ E-mail: _____

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, explain: _____

2) Any recent surgery, including plastic surgery? ❍ No ❍ Yes, explain: _____
_____

3) Any skin cancer? ❍ No ❍ 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, 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	❑	Headaches (chronic)	❑
Hormone imbalance	❑	Hepatitis	❑
Systemic disease	❑	Herpes	❑
High blood pressure	❑	Frequent cold sores	❑
Spinal injury	❑	Immune disorders	❑
Thyroid condition	❑	HIV/AIDS	❑
Hysterectomy	❑	Lupus	❑
Diabetes	❑	Metal bone pins or plates	❑
Heart problem	❑	Phlebitis, blood clots, poor circulation	❑
Varicose veins	❑	Blood clotting abnormalities	❑
Arthritis	❑	Psychological treatment	❑
Asthma	❑	Insomnia	❑
Eczema	❑	Keloid scarring	❑
Epilepsy	❑	Skin disease/skin lesions	❑
Seizure disorder	❑	Any active infection	❑
Fever blisters	❑		

7) Has your physician discussed concerns about raising your body temperature? ❍ No ❍ Yes

explain: _____
_____

Continued ⇨

8) Do you smoke? ❍ No ❍ Yes

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

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

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

List any over the counter medications (including 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, 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, 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

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: _____

Continued ⇨

If yes, please explain: _____

Female Clients Only:

27) Are you taking oral contraceptives? ❍ No ❍ 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, specify: _____

By scheduling an appointment or signing your name below, you agree to allow us to charge the credit card that you provided to us to reserve the appointment based our cancellation charge policy as follows:

Each service is by appointment and we reserve the therapist's time and the room for only one guest at a time, we ask for 24 hours notice for any changes or cancellations on all current and future appointments. Any changes less than 24 hours notice results in losing deposit, any no show results in 100% charge.

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:_____

Client Consultation Form

NAME _____ DATE of BIRTH _____

Consent to have my picture/video taken for marketing and social media purposes.

- ☐ **I consent to pictures**
- ☐ **I consent to videos (all sound is muted, and music is played over**
- ☐ **I consent to pictures but please blackout my eyes and hide my identity**
- ☐ **I do not consent**

What would you like to achieve from your treatment today? _____

_____

YOUR SKIN CARE

1) Have you ever had a facial treatment before? ❍ No ❍ Yes, when? _____

2) Have you ever had a body spa treatment before? ❍ No ❍ Yes

   If yes, please specify when and what treatment: _____

3) Which of the following best describes your skin type? (Please check one)

☐	Type I	Fair skin tones—Always burns, never tans
☐	Type II	Light skin tones—Burns easily, tans slightly
☐	Type III	Fair to olive skin tones—Burns moderately, tans moderately
☐	Type IV	Light brown skin tones—Burns slightly, tans easily
☐	Type V	Dark brown skin tones—Rarely burns, tans easily
☐	Type VI	Dark brown to black skin tones—Never burns, tans easily

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

   If yes, please specify: _____

5) Have you ever had chemicals peels, laser treatments, or microdermabrasion? ❍ No ❍ Yes

   In the last month? ❍ No ❍ Yes

6) Do you use Accutane, Retin-A, Renova, Adapalene Hydroxyl Acid or any other Retinol/vitamin A derivative products? ❍ No ❍ Yes

   If yes, please specify what and when last used: _____

7) Have you used acne medication? ❍ No ❍ Yes, when? _____ Which medication? _____

8) Have you experienced Botox, Restylane, or collagen injections? ❍ No ❍ Yes

   If yes, please specify: _____

9) What skin care products are you currently using? (Checkmark all that apply)

Cleanser _____ Toner _____

Day Moisturizer _____ Night Moisturizer _____

Exfoliator _____ Mask _____

Eye Product _____ SPF/Sunscreen _____

Scrubs _____ Makeup Products_____

10) Have you used any hair removal methods in the past six weeks? ❍ No ❍ Yes (Check all that apply)

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ Tweezing
☐ Stringing ☐ Depilatories ☐ Other: _____

11) What areas of concern do you have regarding your: **Skin** (Check all that apply)

☐ Breakouts/acne	☐ Uneven skin tone	☐ Blackheads/whiteheads
☐ Sun damage	☐ Excessive oil/shine	☐ Wrinkles/fine lines
☐ Rosacea	☐ Dull/dry skin	☐ Broken capillaries
☐ Flaky skin	☐ Redness/ruddiness	☐ Dehydrated
☐ Sun/liver/brown spots	☐ Other: _____	

Eyes (Check all that apply)

☐ Dehydrated	☐ Wrinkles	☐ Puffiness
☐ Dark circles	☐ Other: _____	

Lips (Check all the apply)

☐ Dehydrated ☐ Cracked/chapped lips ☐ Other: _____

12) Have you ever had an allergic reaction to any of the following (Check all that apply)

If yes, please specify: _____

☐ Cosmetics	☐ AHAs	☐ Medication
☐ Fragrance	☐ Food	☐ Shellfish
☐ Animals	☐ Latex	☐ Sunscreens
☐ Drugs	☐ Iodine	☐ Pollen
☐ Other: _____		

13) What SPF do you use on your face? _____ How often/when? _____

14) Have you recently used any self-tanning lotions, creams or treatments? ❍ No ❍ Yes

If yes, please specify: _____

15) Have you had any recent tanning bed or sun exposure that changed the color of your skin? ❍ No ❍ Yes

If yes, please specify: _____

INFORMED CLIENT CONSENT FORM

NAME _____ DATE of BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

Although every precaution will be taken to ensure your safety and well-being before, during, and after your treatment/procedure, please be aware of the following information and possible risks and indicate that you fully understand what to expect. Please initial:

_____ I hereby consent to and authorize the technician/esthetician to perform the following treatment/procedure: _____

_____ I voluntarily agree to undergo this treatment/procedure after the nature and purpose of this treatment/procedure has been explained to me, along with the risks and hazards involved.

_____ Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications.

_____ I understand that it is imperative to my health and safety that I disclose all of the information requested in the Client Consultation/Health History form. I have cited all conditions and circumstances regarding my health history, allergies, and medications, supplements, or prescriptions being taken (orally and/or topically), and any past reactions to products or medications.

_____ I understand that no specific guarantees of the results can or have been made and that there is the possibility I may require additional treatments/procedures to obtain the expected results at an additional cost.

_____ I have read and understand all pre-treatment, post-treatment, and home care instructions. I understand the importance of following all instructions given to me. In the event that I have additional questions or concerns regarding my treatment or post-treatment care, I will consult the technician/esthetician immediately. I understand that if I choose to consult a physician, I do so at my own expense.

_____ I consent to “before-and-after” photographs for the purpose of documentation, potential advertising, and promotional purposes.

I understand that if I have any concerns, I will address these with my technician/esthetician. I give permission to my technician/esthetician to perform the above treatment/procedure we have discussed and will hold him/her/them and his/her/their staff harmless and nameless from any liability that may result from this treatment/procedure. I understand my technician/esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have been provided sufficient opportunity for discussion and to have any questions answered. I understand the procedure and accept the risks. I do not hold the technician/esthetician, whose signature appears below, responsible for any of my conditions that were present but not disclosed at the time of this procedure that may be affected by the treatment performed today.

Client Name (Printed) _____

Client Name (Signature)_____ Date _____

Technician/Esthetician _____ Date _____