126 E Lincoln Hwy
Schererville, IN 46375
www.therejuvenationhouse.com

Client Intake Form

Date: ___________________________

Please take a moment to complete our client profile. The following information will enable us to recommend the best procedures, therapies and treatments, as well as the appropriate home care products. Any information you provide will be kept confidential.

How were you referred to The Rejuvenation House Medi-Spa? ☐ Gift Certificate ☐ Google ☐ Walk-In ☐ Drive by ☐ Event ☐ Email ☐ Facebook/Instagram ☐Friend____________________________________

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, 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? m No m 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)

Client Intake Form Continued

- ☐ Cancer
- ☐ Hormone Imbalance
- ☐ Systemic Disease
- ☐ High Blood Pressure
- ☐ Spinal Injury
- ☐ Hysterectomy
- ☐ Diabetes
- ☐ Heart Problem
- ☐ Varicose Veins
- ☐ Arthritis
- ☐ Asthma
- ☐ Eczema
- ☐ Epilepsy
- ☐ Seizure Disorder
- ☐ Fever blisters
- ☐ Headaches (Chronic)
- ☐ Hepatitis
- ☐ Herpes
- ☐ Frequent Cold Sores
- ☐ Immune Disorders
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Metal bone pins or plates
- ☐ Phlebitis, blood clots, poor circulation
- ☐ Blood clotting abnormalities
- ☐ Psychological treatment
- ☐ Insomnia
- ☐ Keloid Scarring
- ☐ Skin Disease/Skin Lesions
- ☐ Any active infections

7) Has your physician discussed concerns about raising your body temperature? __ No __Yes
explain:____

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 medications you take regularly:____
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 _______________

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: ____________________________________

Client Intake Form Continued

Cancellation Policy (PLEASE READ)

We understand that occasionally you may have to cancel an appointment with us. However, we do ask that you give us enough time in advance to cancel. You will be emailed or texted the day before to confirm your appointment. As a courtesy to our other clients and staff, it is company policy for all clients to give 24 hour notice of cancellation. **All appointment cancellations must be made 24 hours prior to your scheduled appointment time. Any no call no show or canceled appointments less than 3 hours before your scheduled service time will result in a charge of %50 of the scheduled spa service(s) to the credit card on file**. **Medical Services there is a charge of $150.** When you miss an appointment with us, we not only lose your business, but also the potential business of other clients who could have scheduled an appointment for the same time. This policy allows us to retain great therapists.

By signing below, you acknowledge that you have read and understand the Cancellation/Rescheduling Policy for The Rejuvenation House Medi-Spa, LLC as described above.
Thank you for your understanding and for your cooperation.

Clients Printed Name:____

Client Signature: Date:____

Signature Date:____________

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:______________

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Your protected health information will be used by The Rejuvenation House Medi-Spa, LLC or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

NOTICE OF PRIVACY PRACTICES

The Rejuvenation House Medi-Spa, LLC is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the Notice of Privacy Policies and Practices provided to you.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

You may request a restriction on the use or disclosure of your protected health information. However, The Rejuvenation House Medi-Spa, LLC may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification. It is a violation of the federal privacy standards if The Rejuvenation House Medi-Spa, LLC agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Policies and Practices, please consult with a practice representative at the location and contact information listed on the back of the brochure.

YOU MAY REVOKE THIS CONSENT AT ANYTIME

You may revoke this consent at any time; however, The Rejuvenation House Medi-Spa, LLC requires that you must revoke this request in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the dates of your request.

CHANGES TO PRIVACY PRACTICES

The Rejuvenation House Medi-Spa, LLC reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Policies and Practices. The Rejuvenation House Medi-Spa, LLC will notify you of any changes of privacy practices either by mail, at your next appointment or any other pre-approved method that you request.

SIGNATURE

I have reviewed this consent form, received Notice of Privacy Policies and Practices, and given my permission to The Rejuvenation House Medi-Spa, LLC to use and disclose my health information in accordance with this consent and the notice provided.

Client Print Name:____

Client Signature:____
Date:____________

Manager Signature:____
Date:___________