

Confidential Client Health History Form



George Arogia - Owner
Holistic Rejuvenation

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, 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: _____

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 _____

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 check any that apply)

☐ Rash ☐ Irritation ☐ Peeling ☐ Sun Sensitivity ☐ Breakout

26) Have you ever had an allergic reaction to any of the following? (Please check 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: _____

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: _____

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