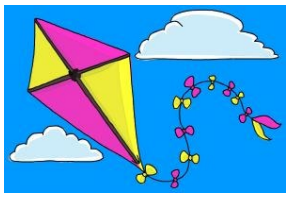

Above & Beyond DaySpa

Client Information

Date: _____ Date of birth:_____
Name: _____
Address: _____
Home Phone#: _____ Cell Phone#:_____ Work Phone# _____
Email Address: _____
Would you like to receive email notifications of specials? Yes / No
Emergency Contact: _____
Emergency Contact Phone# _____

Medications:

Vitamin Supplements:

Allergies:

Are you pregnant? Yes / No
Are you nursing? Yes / No
Do you smoke? Yes / No
Do you drink alcohol? Yes / No If yes, how much per day? _____
Are you currently undergoing chemotherapy or radiation treatments? Yes / No

OVER

Do you have any metal in your body such as dental work, metal plates, or pins? Yes / No
Are you currently under the care of a dermatologist? Yes / No
Dermatologist's name: _____
Primary Care Provider: _____ Phone # _____

Have you used Isotretinoin (Accutane) in the past year? Yes / No

Are you currently using Tretinoin (Retin-A)? Yes / No If yes, when did you last apply? _____

Do you consistently wear sunscreen? Yes / No
How many glasses of water do you consume each day? _____
On a scale of 1 to 10 with 1 being the lowest and 10 being the highest, how do you rate your skin's current condition? _____
On a scale of 1 to 10, with 1 being the lowest and 10 being the highest, what is your current stress level? _____
What products are you currently using on your skin?

What are your goals for your skin? List in order of importance:

Any other information you'd like to share?