Facial/Body Health History Form

General

Client Name:__________________ Date:__________ Address: ____________________
City:______________ State: ____ Zip: ______ Phone Number: ______________ Cell Home Work (circle)
Email: ________________ Birthday: __________ Age: ☐ Under 21 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61+
Emergency Contact: ______________________________ Phone: __________________
What are your primary skin care goals/concerns?______________________________
What other treatments are you interested in? (circle all that apply):
Facial Treatment Waxing Spa Treatment Body Treatment

Skin

Have you had chemical peels, microdermabrasion, or any resurfacing treatments? If yes, specify: ______________
Do you use any prescription skin products (i.e. Accutane, Retin-A, Renova, Adapalene) If yes, specify: ______________

Please circle all that apply:

Are you currently using any products that contain any of the following ingredients?
Glycolic Acid Lactic Acid Salicylic Acid Exfoliating Scrubs Vitamin A Derivatives
Do you have a tendency to redness? Do you experience an oily shine throughout the day?
Do you ever experience skin breakouts?
What are you using in your current skin care regime (check all that apply and specify brand and type): Soap ☐ __________
Cleanser ☐ __________ Toner ☐ __________ Exfoliator ☐ __________
Moisturizer ☐ __________ Sun Protection ☐ __________ Mask ☐ __________
Specialty ☐ __________ Eye Treatment ☐ __________ Other Products: __________

Male Clients only:

What products do you use during your shaving regime?____________________
Do you experience shaving irritation/ingrown hairs? ☐ yes ☐ no
How many times do you shave per week? ☐ 0-2 ☐ 3-5 ☐ 6-7 ☐ 7+

Health

Have you been under a physician's care within the last year? ☐ yes ☐ no If yes, specify:________________
List any regularly taken medications, vitamins, supplements, etc..____________________

Please circle all that apply:

Blood Pressure Heart Problems Pacemaker Diabetes Epilepsy Asthma Sinus Problems Hormonal Problems Cold Sores
Claustrophobia Recent Dental X-rays Metal Implants or Body Piercings Vericose Veins: If yes, specify location: __________
Have you had allergic reactions to any of the following: Fragrances: If yes, specify:________________
Food: If yes, specify:________________ Animals: If yes, specify: ________________
Medicine: If yes, specify:________________ Cosmetics: If yes, specify:________________
Specific Ingredients: If yes, specify: ________________ Other: ________________
Other health issues: ☐ yes ☐ no If yes, specify: ________________________

Female Clients only:

Are you taking oral contraception? ☐ yes ☐ no Currently having or due for your menstrual period? ☐ yes ☐ no
Are you pregnant or trying to become pregnant? ☐ yes ☐ no Are you currently breast feeding? ☐ yes ☐ no

Lifestyle

Do you exercise regularly? ☐ yes ☐ no Do you follow a restricted diet? ☐ yes ☐ no If yes, specify: ____________________

How much water do you intake daily? ____________________

How many alcoholic beverages do you consume weekly? ☐ 0-1 ☐ 2-6 ☐ 6+

How many caffeinated beverages do you consume daily? ☐ 0-2 ☐ 2-4 ☐ 4+

Do you smoke? ☐ yes ☐ no Rate your stress level on a scale of 1 to 5 (1=lowest, 5=highest). ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you sunbathe or use tanning beds? ☐ yes ☐ no If yes, how often? ____________________

I acknowledge that this information is accurate to the best of my knowledge.

Please note that you will be asked to sign this each time you receive a treatment to verify that all Consultation Card information is updated and accurate.

Signature ____________________

________ Date ________ Date ________ Date ________ Date