Confidential Client Health History Form

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)

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

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 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: _____

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? m No m 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: _____

I hereby consent to and authorize _____**Shana R. Bowman, LE**_____ to perform the following procedure:

_____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by _**Shana R. Bowman, LE** _.

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed) _____

Client Name (signature) _____Date_____

Esthetician _____ Date_____

Client Skin Analysis/Evaluation Form

Name: _____ Date of Consult: _____

Address: _____ Age: _____ Gender: _____

City: _____ State: _____ Zip: _____

Known Allergies: _____

Medications: _____

Skin Classification

Fitzpatrick Classification: Type I Type II Type III Type IV Type V Type VI

Normal _____
Dry_____
Dehydrated_____
Mature _____
Thin, sensitive skin _____
Oily _____
Open pores _____
Comedones blackheads)_____
Milium (whiteheads)_____
Asphyxiated (blocked pores and follicles) _____
Blemishes/Acne_____
How many years? _____
Vulgaris: m No m Yes Chronic: m No m Yes Cystic: m No m Yes Rosacea: m No m Yes

Scars (acne, etc)_____
Photoaging_____
Wrinkles _____
Superficial lines_____
Deep lines_____
Relaxed elasticity_____
Good elasticity_____
Couperose (broken capillaries)_____
Dilated capillaries_____
Discolorations _____
Other:_____
_____
_____
_____

Date: _____ Skin Care Professional: _____

Specific Concerns: _____

Type of treatment: _____

Notes/Remarks: _____

Recommended Home Skin Care Products:

For Daytime:

_____
_____
_____
_____

For Nighttime:

_____
_____
_____
_____

Date: _____

Client name: _____

I recommend the following professional treatments for you to help achieve the results you desire:

Treatment Type: _____
Schedule every ____days/weeks Date scheduled: _____
___Series recommended of _____# of treatments

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Schedule every ____days/weeks Date scheduled: _____
___Series recommended of _____# of treatments

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Home Care

___ Cleanser: _____ How often: _____
___ Exfoliant: _____ How often: _____
___ Serum: _____ How often: _____
___ Serum: _____ How often: _____
___ Moisturizer: _____ How often: _____
___ SPF: _____ How often: _____
___ Repair Tx: _____ How often: _____
___ Mask: _____ How often: _____
___ Mask: _____ How often: _____
___ Spot Tx: _____ How often: _____
___ Other: _____ How often: _____

If you have any questions about your treatment plan, or of when and how to use your home care products, please contact me any time. Your treatment plan may change depending on the rate of progress and changes in your skin.

___ (initial) I understand that to achieve maximum benefits and maintain the results from my professional treatments, home care product use as outlined above is essential.

___ I commit to my success by pledging to wear sunscreen daily.

_____ _____

Client's signature Esthetician's signature