Confidential Client Health History & Skin Care Consultation Form

Date : _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Single: □No □Yes Married: □No □Yes, anniversary date: _____

Employer: _____ **Occupation:** _____

Does your job require you to work outdoors? _____

How did you find us? _____

What would you like to achieve from your treatments here? _____

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 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	□
Hormone imbalance	□	Hepatitis	□
Systemic disease	□	Herpes Simplex	□
High blood pressure	□	Frequent cold sores/fever blisters	□
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 or Psoriasis	□	Keloid scarring	□
Epilepsy Seizure disorder	□	Skin disease/skin lesions	□
Autoimmune Disease	□	Chicken Pox/Shingles	□
Polycystic Ovary Syndrome (PCOS)	□	Any active infection	□

6) Has your physician discussed concerns about raising your body temperature? □No □Yes
Explain: _____

7) Do you smoke? □No □Yes

8) Do you follow a restricted diet? □No □Yes, specify: _____

9) Do you follow a regular exercise program? □No □Yes, specify: _____

10) What is your stress level? □High □Medium □Low

11) List any medications you take regularly: _____

12) List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:
_____

13) Do you form thick or raised scars from cuts or burns? □No □Yes

14) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? □No □Yes, describe: _____

15) List your daily consumption in ounces of: _____ Water _____ Caffeine _____ Alcohol

16) Do you experience any problems sleeping? □No □Yes How many hours a night do you typically sleep? _____

17) Do you wear contact lenses? □No □Yes

18) Have you had sun exposure or used in a tanning bed in the last 48 hours that changed the color of your skin? □No □Yes

19) How frequently are you exposed to the sun or use a tanning bed? __Infrequently __ Frequently __Regularly

20) Do you have metal implants or wear a pacemaker? □No □Yes

21) Have you ever experienced claustrophobia? □No □Yes

22) Do you suffer from sinus problems? □No □Yes

23) Have you ever had an adverse reaction after using any skin care product? (Circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

24) Have you ever had an allergic reaction to any of the following? (Circle any that apply)

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen

AHAs Fragrance Shellfish Latex Drugs Other: _____

25) Do you consider your skin to be sensitive? □No □Yes 26) Do you hydrate your skin daily? □No □Yes

27) Do you exfoliate your skin regularly? □No □Yes 28) Do you detoxify your skin regularly? □No □Yes

YOUR SKIN CARE

1) Have you ever had a facial treatment before? □No □Yes, when was last treatment? _____

2) Have you ever had a body spa treatment before? □No □Yes, when was last treatment? _____

Massage:	□No	□Yes
Salt Glow:	□No	□Yes
Seaweed Wrap:	□No	□Yes
Mud Wrap:	□No	□Yes
Body Scrub:	□No	□Yes

Other: _____

3) Which of the following best describes your skin type? **(Please circle only one type number)**

I	Always burn easily, never tans, very fair skin, freckles; red and blonde hair; blue eyes
II	Always burns, tans slightly, some freckles; fair, sandy/red hair; green or blue eyes
III	Burns moderately, tans gradually; brown, fair sandy hair; green, hazel, blue eyes
IV	Seldom burns, always tans well; dark brown hair; green, hazel and brown eyes
V	Rarely burns, tans deeply; dark and black hair, brown and dark brown eyes
VI	Never burns, deeply pigmented; black hair, dark brown eyes

4) Do you have any special skin problems or concerns pertaining to your face or body? □No □Yes
Specify: _____

5) Have you ever had chemical peels, laser or microdermabrasion? □No □Yes
In the last month? □No □Yes

6) Do you use Retin-A, Renova, Adapalene Hydroxy Acid or Retinol/Vitamin A derivative products? □No □Yes Describe:
_____

7) Have you used any of these products in the last 3 months? □No □Yes

8) Have you used any prescribed acne medication? □No □Yes, when? _____Which drug?_____

9) What skin care products are you currently using? (List brand where known)

□ Soap _____ □ Shower gels _____
□ Toner _____ □ Body Lotions _____
□ Mask _____ □ Sunscreen _____
□ Eye Product _____ □SPF_____
□ Cleanser _____ □ Night Moisturizer/Cream _____
□ Day Moisturizer_____ □ Makeup Products _____
□ Exfoliator _____ □ Scrubs _____
Other _____

10) Have you recently used any self-tanning lotions, creams or treatments? □No □Yes, specify:
_____

11) Have you used any of the following hair removal methods in the past six weeks? (Circle all that apply)

Sugaring Shaving Waxing Electrolysis Tweezing Threading Depilatories

Have you ever been sugared? □No □Yes, when was last treatment? _____

12) What areas of concern do you have regarding your…

Skin: *(Please check all that apply and explain.)*

- □ *Breakouts/acne*
- □ *Blackheads or Whiteheads*
- □ *Excessive oil/shine*
- □ *Rosacea*
- □ *Broken capillaries*
- □ *Redness/ruddiness*
- □ *Sun spots/liver spots/ brown spots*
- □ *Uneven skin tone*
- □ *Sun damage*
- □ *Wrinkles/fine lines*
- □ *Dull/dry skin*
- □ *Flaky skin*
- □ *Dehydrated*
- □ *Other:* _____

Eyes: *(Please check all that apply and explain.)*
□ *Dehydrated* □ *Wrinkles* □ *Puffiness* □ *Dark Circles* □ *Other:* _____

Lips: *(Please check all that apply and explain.)*
□ *Dehydrated* □ *Cracked/chapped* □ *Other:* _____

13) What SPF do you use on your face? _____ **How often/when?**_____

14) What SPF do you use on your body?_____ **How often/when?**_____

15) Have you experienced Botox, Restylane or Collagen injections? □No □Yes, specify: _____
What is the date of your last injection? _____

FEMALE CLIENTS ONLY:
16) Are you taking oral contraceptives? □No □Yes, specify: _____

17) Any recent changes to or from your contraceptive treatment? □No □Yes
If so, what and when: _____

18) Are you pregnant or trying to become pregnant? □No □Yes

19) Are you lactating? □No □Yes

20) Are you postmenopausal? □No □Yes

21) Any menopause problems? □No □Yes, specify: _____

22) Are you undergoing any hormone replacement therapy? □No □Yes, specify: _____

MALE CLIENTS ONLY:
23) What is your current shaving system? □Wet shave □Electric

24) Do you experience irritation from shaving? □No □Yes Ingrown hairs? □No □Yes

Please use this space to complete answers where space was insufficient. **(Please include the number of the question)**

_____
_____
_____
_____

Future Appointments/Contact:

May we call you at your home or at your cell phone number to confirm future appointments? □No □Yes
May we contact you via mail/email about future promotions and news? □No □Yes

I agree to receive text messages to this mobile phone number (_____) _____-_____ reminding me about my upcoming appointments with Spatique Wellness, LLC (dba Spatique Skin Care). I understand that SMS reminders are optional and that message and data rates may apply. My mobile provider is _____ .

□ Please send both text and email notifications about my appointments.

□ I prefer to receive only email notifications about my appointments.

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 skin care therapist or massage therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this establishment and/or therapists from liability and assume full responsibility thereof.

Client Signature:_____ Date: _____

Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to: chemical peels, CryoClear®, microdermabrasion, body treatments, microcurrent therapy, LED phototherapy, microablation, electrolysis, facial toning, body sugaring hair removal and other forms of epilation, permanent cosmetics, ionization, laser treatments, tattoo removal, vein treatments, brown spot removal, BOTOX, collagen, dermal fillers, sclerotherapy, mesotherapy, dermaplaning, and various other beauty procedures is not an exact science and no specific guaranties can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to realize a difference.

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications of treatments I have voluntarily elected to undergo. I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance. I also recognize that independent results are dependent upon my 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 with the skin care professional immediately.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability Spatique Wellness, LLC and the individual that provided my treatment, the insured, and any additional insureds, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may affect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

Client Signature:_____ Date:_____

Printed Name: _____

Model Release

In consideration for treatment received, I hereby grant permission to Spatique Wellness, LLC and the individual that provided my treatment to use any photographic treatment records for the purposes of clinical and statistical studies, advertising, or promotion without any additional compensation to me.

Client Signature:_____ Date:_____

Printed Name: _____