Confidential Client Information and Release Form

**It is our desire to provide you the best possible consultation, cosmetics and skin care treatment. Please take just a moment to answer the following questions.

Full Name: ______________________________ Date of Birth: ___/___/___

Address: ______________________________ Telephone:

______________________________ (Home) ______________

City: ______________ State: ___ Zip Code: ______ (Work) ______________

E-Mail Address:______________________________ (Mobile) ______________

Occupation: ______________________________

Emergency Contact: ______________________ Telephone: ______________

How did you hear about us? ☐ ☐ Friend ☐ ☐ Newspaper Internet Mailer

Friend's Name: ______________________________

Medical History

Please check any symptoms or physical problems listed below that you currently experience or have experienced in the past.

- ☐ Allergies
- ☐ Asthma
- ☐ Anemia
- ☐ Anticoagulants
- ☐ Arthritis
- ☐ Cancer
- ☐ Circulatory
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy or Seizures
- ☐ Glandular
- ☐ Headache
- ☐ Heart
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hormonal
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ I.U.D.
- ☐ Low Blood Pressure
- ☐ Metallic Implants
- ☐ Neck Pain/Stiff Neck
- ☐ Numbness
- ☐ Pacemaker
- ☐ Pregnant
- ☐ Sinuses
- ☐ Spinal Curvature
- ☐ Stress/Anxiety
- ☐ Stroke
- ☐ TMJ Disorder
- ☐ Virus
- ☐ Vision
- ☐ Weakness
- ☐ Other____________

Skin Conditions

- ☐ Acne
- ☐ Age Spots
- ☐ Broken Capillaries
- ☐ Comedones
- ☐ Eczema
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Milia
- ☐ Moles
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Warts

Allergies / Medications

Please list all medications you take internally, including Accutane (and when last taken?):

____

____

____

Please list all medications you regularly use topically, include Retin-A, AHA's:

____

Do you take any vitamins / supplements? ☐ Yes ☐ No

If yes, please explain: ______________________________

Are you currently taking hormones or birth control pills? ☐ Yes ☐ No

If yes, please list: ______________________________

Are you a smoker? ☐ Yes ☐ No If yes, how much? ______________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how much / frequency? ______________

How many glasses of water (8 oz.) do you drink per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

Do you exercise regularly? ☐ Yes ☐ No

Do you have any problems with constipation? ______________________

Are you currently under any medical/dermatological care? ☐ Yes ☐ No

If yes, please explain: ______________________________

Do you have any allergies or allergic reactions? ______________________

How much sun exposure do you receive? ☐ Extensive ☐ Average ☐ Minimal

Do you use an SPF regularly? ☐ Yes ☐ No

Have you had any surgeries in the last five years? ☐ Yes ☐ No If yes, please list

____

Have you had any cosmetic surgeries? ☐ Yes ☐ No If yes, please explain

____

How often do you receive facials?_______________________________________

Skin care services you would be interested in:Conditions

- ☐ Professional Facial
- ☐ Microdermabrasion
- ☐ Glycolic Peels
- ☐ Hand and Foot Treatment
- ☐ Hydrating Mask
- ☐ Massages
- ☐ Oxygen Treatment
- ☐ Other______________________________

Additional Comments:

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