

Confidential Client History & Consent Form

Date: _____

Name: _____ D.O.B.: _____

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Emergency Contact: _____ Phone: _____

How did you hear about us (i.e. website, friends name, newspaper, ad, Facebook, etc)?
_____Please list any questions or concerns that you have with your skin and/or the reason for your visit:

_____Which skincare and cosmetic products are you currently using? _____

_____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) Have you had any of the following health conditions in the past or present?

- | | | | |
|-------------------------|--------------------------|----------------------------|--------------------------|
| Cancer | <input type="checkbox"/> | Headaches | <input type="checkbox"/> |
| Hormone Imbalance | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> |
| High/low blood pressure | <input type="checkbox"/> | Fever blisters/cold sores | <input type="checkbox"/> |
| Hysterectomy | <input type="checkbox"/> | Immune disorders | <input type="checkbox"/> |
| Spinal injury | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Poor circulation | <input type="checkbox"/> |
| Heart problem | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> |
| Varicose veins | <input type="checkbox"/> | Skin diseases/skin lesions | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Any active infections | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Eczema | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | Scar easily (Keloid) | <input type="checkbox"/> |
| Gold Therapy | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> |

4) Do you smoke? No Yes

5) Do you follow a restricted diet? No Yes

6) What is your stress level? High Medium Low

7) List any medications or vitamins you are taking regularly: _____

8) Do you wear contact lenses? No Yes Lash Extensions? Yes No

9) Have you been exposed to the sun or a tanning bed within the last 48 hours? No Yes

10) Do you use or have you ever used Adapalene, Glycolic Acid, AHA, Accutane, Retin-A, Renova, Differin Gel, Salicylic Acid or any vitamin A derivative product (**Accutane**)? No Yes

If yes, please explain: _____

11) Have you ever experienced an allergic reaction to any of the following? (Please circle any that apply)

Cosmetics	Medicine	Food	Sunscreens	Iodine	AHAs
Fragrance	Shellfish	Latex	Other: _____		

If yes, please explain: _____

12) Have you ever-experienced claustrophobia? No Yes

Female Clients Only

13) Are you taking any oral contraceptives? No Yes

14) Are you pregnant or trying to become pregnant? No Yes

15) What is the date of your last menstrual cycle? _____

16) Are you experiencing any menopause problems? No Yes

I consent to photos being used for office use. No Yes

I consent to photos being used for advertising. No Yes

I understand, have read and fully completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. While all treatments are recommended to achieve the best possible results, I do understand that not all treatments will have the same results on every client; therefore no guarantee can be given. I also 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 technician of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Begin with Skin Med Spa, LLC and my esthetician from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____

Update:

I have reviewed my confidential history form and have no changes to my health history and haven't started any new medications.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____