Client Information

Name:_____ Cell phone: ( )_____ Date of Birth:_____

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

Referred by:_____Email _____

In Case of Emergency:_____ Home phone: ( )_____

General & Medical Information

Occupation:_____ Height:_____ Weight:_____ [ ]F [ ]M

Are you in good health? [ ] Yes [ ] No Age: _____

Has there been any change to your health in the past year? [ ] Yes [ ] No

If so, please explain:_____

Physician:_____

If you answer "yes" to any of the following questions, please explain as clearly as possible in the space provided.

Do you suffer from acne? [ ] Yes [ ] No
Do you suffer from allergies? [ ] Yes [ ] No
Do you have arthritis? [ ] Yes [ ] No
Do you have high blood pressure? [ ] Yes [ ] No
If yes, what medication are you taking?
_____

Do you suffer from epilepsy or seizures? [ ] Yes [ ] No
Do you suffer from claustrophobia? [ ] Yes [ ] No
Do you have varicose veins or distended capillaries? [ ] Yes [ ] No
Do you have any contagious diseases? [ ] Yes [ ] No
Do you have heart disease? [ ] Yes [ ] No
Do you have asthma? [ ] Yes [ ] No
Have you ever had or currently have cancer? [ ] Yes [ ] No
Please explain:_____
_____

Do you suffer from a blood disorder? [ ] Yes [ ] No
Do you have seborrhea? [ ] Yes [ ] No
Please explain:_____
_____

Are you pregnant or nursing? [ ] Yes [ ] No
Do you wear contact lenses? [ ] Yes [ ] No

Do you wear dentures? [ ] Yes [ ] No
Do you have a pacemaker? [ ] Yes [ ] No
Are you currently being treated by physicians for any condition? [ ] Yes [ ]No
Please explain:_____
Do you have any other medical condition I should know about?_____

Are you taking any medications (including non-prescription drugs)?

Birth Control Pills [ ] Yes [ ] No Diuretics [ ] Yes [ ] No

Accutane [ ] Yes [ ] No Vitamins/Supplements [ ] Yes [ ] No

Hormone Therapy [ ] Yes [ ] No Antibiotics [ ] Yes [ ] No

Aspirin [ ] Yes [ ] No Vitamin A (topical/internal) [ ] Yes [ ]No

Renova [ ] Yes [ ] No Benzoyl Peroxide [ ] Yes [ ] No

Glycolic Acid [ ] Yes [ ] No Retin A [ ] Yes [ ] No

How much water do you drink a day?_____ glasses
Have you ever had surgery? [ ] Yes [ ] No
Do you exercise regularly? [ ] Yes [ ] No
How would you describe your overall level of stress?
[ ] Low [ ] Medium [ ] High

Please take a moment to carefully read the following information you have provided and sign where indicated. If you have a specific medical condition or specific symptoms, certain massage or esthetic treatments may be contraindicated. A referral from your primary care provider may be required prior to services being rendered. If I experience any pain or discomfort during this session I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my comfort level. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature:_____ Date:_____

Practitioner Signature:_____ Date:_____