FLAGSTAFF Face & Body
professional skin care and body therapy

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL INFORMATION

Client Name_____ Today's date_____

Date of Birth_____ Age_____ Occupation_____

Address_____ City_____ St_____ Zip_____

Please only provide phone numbers that we may use to contact you. Thank you.

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____

Whom may we thank for referring you and/or how did you hear about us?_____

MEDICAL HISTORY

Do you wear contact lenses?	Yes	No
Do you experience frequent headaches?	Yes	No
Do you wear dentures?	Yes	No
Do you have psoriasis?	Yes	No
Do you suffer from edema? (Swelling)	Yes	No
Do you have eczema?	Yes	No
Have you ever had fever blisters/cold sores?	Yes	No
Do you currently have any cuts or abrasions?	Yes	No
Do you currently have any warts?	Yes	No
Do you have any undiagnosed lumps or bumps?	Yes	No
Do you hyperpigment (darkening) or hypopigment (lightening) of the skin after physical trauma?	Yes	No
Do you have phlebitis?	Yes	No
Do you have any skin diseases? Explain:	Yes	No
Do you form thick or raised scars from injury?	Yes	No
Do you have diabetes?	Yes	No
Do you have osteoporosis?	Yes	No
Do you have epilepsy?	Yes	No
Do you have asthma?	Yes	No
Do you suffer from arthritis?	Yes	No
Do you suffer from hypo/hyperthyroidism?	Yes	No
Do you have HIV/AIDS?	Yes	No
Do you have hepatitis?	Yes	No
Do you have any other contagious diseases? List:	Yes	No
Do you suffer from hormone imbalance? Explain:	Yes	No

Have you had cancer in the last two years? Explain:	Yes	No
Do you have high blood pressure?	Yes	No
Do you bruise easily?	Yes	No
Do you have hypersensitive skin?	Yes	No
Do you have varicose veins?	Yes	No
Do you have cardiac or circulatory conditions? Explain:	Yes	No
Do you suffer from mitral valve prolapse?	Yes	No
Do you have a pacemaker?	Yes	No
Do you take blood thinners? List:	Yes	No
Do you have a blood disorder? Explain:	Yes	No
Have you broken any bones in the past 2 years?	Yes	No
Have you had surgery in the past 2 years? Explain:	Yes	No
Have you had any recent infections? Explain:	Yes	No
Do you take birth control pills/shots?	Yes	No
Are you currently pregnant or lactating?	Yes	No
Are you currently or in the last year been under the care of a dermatologist? Explain:	Yes	No
Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Explain:	Yes	No

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MEDICAL HISTORY– *CONTINUED*

Skin History

Emergency Contact:_____ Phone:_____
Primary Care Provider:_____ Phone:_____
Do you have any other health problems or medical conditions not listed?_____

_____

Please list any medications, topical, creams, or herbal supplements that you are taking:_____

_____

_____

Do you use any of the following? *Please check all that apply*
☐Retin-A or Retinol ☐Accutane or acne medicine ☐Glycolic Acid ☐AHA's ☐Lactic Acid ☐Any exfoliating scrub
Do you have any allergies? If so, list: _____
Have you had an allergic reaction to any listed below? (Please check all that apply)
☐Food ☐Latex ☐Aspirin ☐Lidocaine ☐Hydrocortisone ☐Iodine ☐Fragrance ☐Cosmetics
☐Hydroquinone or other skin bleaching agents
Describe: _____
Do you experience: ☐Skin breakouts ☐Oily shine ☐Flakiness ☐Tightness ☐Obvious dryness
What skin products do you currently use in your skincare routine? ☐Soap ☐Cleanser ☐Toner ☐Moisturizer
☐Masque ☐Exfoliator ☐Eye product ☐Sunscreen SPF 30 ☐Other _____

Laser Hair Removal

Have you previously had laser hair removal? If yes, when?_____
Have you used any of the following hair removal methods in the past six weeks?
☐Shaving ☐Waxing ☐Electrolysis ☐Tweezing ☐Threading ☐Depilatories
Have you recently had any sun exposure that changed the color of your skin? Yes No
Have you recently used any self-tanning lotions or treatments? Yes No
Initial: _____

Massage

Do you have any numbness or stabbing pains anywhere?_____
Do you have any tension or soreness in a particular area?_____
Are you very sensitive to touch or pressure in any area?_____
Have you been in a vehicular or traumatic accident in the last 2 years?_____
Initial: _____

Tinting

Have you previously had eye brow or eye lash tinting treatment? Yes No
Have you ever had any adverse reactions to tinting? Yes No
I understand that the tinting procedure that I am receiving is temporary. The tint will fade and it is not a permanent procedure.
Initial: _____

Waxing

Have you previously had any waxing treatments?_____
Have you ever had any adverse reactions to waxing? _____
Initial: _____

CHECK ALL THE TREATMENTS AND SERVICES THAT YOU CONSENT TO HAVING:

- ☐ Nail Care (Manicures & Pedicures)
- ☐ Waxing
- ☐ Tinting
- ☐ Massage
- ☐ Body Treatments
- ☐ Skin Treatments (facials, etc.)
- ☐ Permanent Makeup
- ☐ Advanced/ Medical Treatments (additional consent forms required)

Please read the following information carefully and sign where indicated. If you have a specific medical condition or specific symptoms, some treatments may be contraindicated. In this case a referral from your physician may be required prior to providing service.

Because some treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep practitioner(s) updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage, bodywork, or skin therapy observations should not be constructed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. 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. I am also aware that temperatures of towels, stones, or other implements used during treatments may vary. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure, temperature, and/ or stroke may be adjusted to my level of comfort.

I understand that following waxing procedure(s), I should: apply a sunblock with an minimum SPF of at least 30, avoid direct sun exposure or artificial UV exposure (tanning bed) immediately before and after waxing, avoid bathing in hot water directly before or after waxing, avoid using soap to clean the waxed area for 48 hours, avoid application of exfoliants like Retin-A or AHA product(s) for 48 hours. It has also been explained to me that the following may occur after treatment: Skin redness, sensitivity, slight irritation, swelling, mild discomfort, break out. Please note that you may be more sensitive to the waxing procedure if you are premenstrual and/or taking antibiotic(s). I understand that I am responsible for notifying the waxing specialist should any of the above information change prior to any waxing treatment.

Client Signature: _____ Date: _____