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 Information

Please check below 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
□ 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 Related Conditions

□ Acne
□ Age Spots
□ Broken Capillaries
□ Comedones
□ Eczema
□ Hyperpigmentation
□ Hypopigmentación
□ Milia
□ Moles
□ Psoriasis
□ Rosacea
□ Warts

Physician / Dermatologist: _____ City / State _____ Telephone _____
¿Do I have your permission to contact your physician or dermatologist for release to provide you a skin care treatment? □ Yes □ No

Signature: x_____ Date: ___/___/___

Medications / Allergies / Treatments

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:
_____

Are you taking any vitamins / supplements? □ Yes □ No
If yes, please explain: _____

Are you currently under hormones or birth control pills? □ Yes □ No
If yes, please list: _____

Do you smoke? □ Yes □ No If yes, how much? _____

Do you drink alcohol? □ Yes □ No If yes, how much / frequency? _____

Is your weight stable? □ Yes □ No
If no, please explain: _____

How often do you consume the following foods? 1-frequently 2-infrequently 3-never

__ caffeine __ soda __ smoked __ salt __ dairy __ meat __ sweets __ fried

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

Please describe your exercise program and regularity: _____

Do you have problems with constipation? _____

Are you currently under any medical/dermatological care? □ Yes □ No
If yes, please explain: _____

Please list any allergies or allergic reactions: _____

Do you suffer from Nerves, Hypertension, Chronic Worry, Depression, or Anxiety? _____

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

What SPF do you use? _____

Please list any surgeries you have had in the last five years:
_____

Have you had any cosmetic surgeries? □ Yes □ No
If yes, please explain_____

Skin care products and services previously used
Have you ever experienced any of the following:

- ☐ Professional Facial
- ☐ Microdermabrasion
- ☐ IPL Photofacial/Fractional
- ☐ L
- ☐ Laser Hair Removal
- ☐ Glycolic Peels
- ☐ Salicylic Peels
- ☐ Waxing
- ☐ Cleansers
- ☐ Tonic
- ☐ Moisturizers __Day __Night
- ☐ Eye Cream
- ☐ Mask
- ☐ Sunblock SPF _____
- ☐ Other _____

Please describe the results you achieved:
_____
_____
_____

When was your last facial treatment? _____

Skin care services you would be interested in:

- ☐ Professional Facial
- ☐ Microdermabrasion
- ☐ LED Light Therapy
- ☐ Silk Peels
- ☐ Glycolic Peels
- ☐ Salicylic Peels
- ☐ Waxing
- ☐ Massages
- ☐ Hand and Foot Treatment
- ☐ Body Detox
- ☐ Other: _____
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Additional comments:
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Cancellation Policy

Cancellations must be received 24 hours in advance for all appointments. If we do not receive the required notice, we will charge your account for the full amount of the service scheduled.

We sincerely appreciate your consideration in honoring our cancellation policy.

Patient signature _____

Date ___/___/___

Witness _____

Date ___/___/___