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 or Seizures
- ☐ Glandular
- ☐ Headache
- ☐ Had a professional massage
- ☐ Suffer from back pain
- ☐ Liver Disorder
- ☐ Heart
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hormonal
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ I.U.D.
- ☐ Low Blood Pressure
- ☐ Metallic Implants
- ☐ Neck Pain/Stiff Neck
- ☐ Broken bones in past 2 years
- ☐ Very Sensitive to Touch
- ☐ Kidney Disorder
- ☐ Numbness or stabbing pains
- ☐ Pacemaker
- ☐ Pregnant
- ☐ Sinuses
- ☐ Spinal curvature
- ☐ Stress / Anxiety
- ☐ Stroke
- ☐ TMJ Disorder
- ☐ Tumors
- ☐ Virus
- ☐ Vision (wear contact lenses)
- ☐ Weakness
- ☐ Specific Tension or Soreness
- ☐ Other _____

_____**Please initial**

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: _____
What is your approximate weight and height? _____

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: _____
Have you ever done yoga? ☐ Yes ☐ No

How many times a day do you have a bowel movement? _____

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

Please list any allergies, including food or allergic reactions such as to latex, etc…
_____
_____

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

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

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

_____ **Please initial**

Skin Information

What SPF do you use? _____
_____

Do you think you have cellulite? _____

Skin Related Conditions

- ☐ Acne
- ☐ Age Spots
- ☐ Broken Capillaries
- ☐ Comedones
- ☐ Eczema
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ 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

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

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

Please describe the results you achieved:
_____
_____
_____

When was your last facial or body 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
- ☐ Body Wrap
- ☐ Body Scrub
- ☐ Other _____
  _____

_____ **Please initial**

Food

Please list any fruits or vegetable you do not like_____
_____

Do you like water infusions? ☐Yes ☐No If yes, cucumber or citrus _____

What are your favorite fruit juices?
_____

Do you like teas? ☐Yes ☐No If yes, do you prefer hot or iced? _____

Additional information needed:

Please tell us your reason for doing the Detox program _____
_____
_____

Will you be able to drink our Detox tea for 7 days prior to program? ☐Yes ☐No

Will you be able to follow the Detox program for an additional 2 days at home? ☐Yes ☐No

Do you have any problems going up and down stairs? ☐Yes ☐No

Please eat light the day before and nothing but water after 6 PM. Be sure to drink plenty of water during the day.

What to Bring:

"Yourself," with a big smile and a positive attitude. You will have a wonderful day.

Come dressed in easy workout / stretching attire.

If you have specific music (CD) you wish to listen to.

If you wish to read, you may bring reading material.

Please no cell phones or laptops etc… (*we want you to totally relax*)

Information and Suggestions for the Client for Massages / Body Treatments

Please don't bring jewelry or anything of value with you.

As a rule, massage / bodywork are given while you are unclothed. We provide a top sheet and or towel.
During your massage / bodywork you may want to give your therapist feedback as to pressure (deeper or lighter) or point out painful or ticklish areas of the body.
Feel free to ask your therapist any questions about their procedure. Your therapist is a highly trained professional and will be happy to make you feel well informed and comfortable.

_____**Please initial**

Note: Herbal cellulite treatment is an extremely active treatment. Heightened blood circulation should be expected. The hot tingling experience may last for up to 20 minutes and rosy coloring up to two hours.

PLEASE TAKE AMOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED.

(If you have a specific medical condition or specific symptoms, massage / bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.) I understand that massage / bodywork I receive is provided for the basic purpose of relaxation. If I experience any pain or discomfort during this session, I immediately inform the therapist so that the pressure and / or strokes may be adjusted to my level of comfort. I further understand that massage / bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage / bodywork therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage / bodywork 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 the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapists part should I neglect to do so. It is also understood 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.

Clients Signature _____ **Date** _____

Additional comments:

I _____, agree not to hold responsible Carmen E. Reyes-Velez, Rafael A. Velez, Skin Care by Carmen, Anya's European Choice, its successors and assigns for any loss, damage, allergic reaction and or any and all legal liability arising from any treatment, products, body creams, soup, teas, etc., used in the above mentioned treatment with the purpose of detoxifying my body.

_____ _____

Signature **Date**

_____ _____

Witness **Date**

We look forward to working with you and helping you achieve your Wellness goals!