Results Weight Loss and Med Spa

Client Health Profile

Name: _____ Date: _____

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

Cell Phone: _____ Home: _____ Work: _____

Email: _____

Referred By: _____ Birthdate: _____

Height: _____ Weight: _____ Female Male Married Single

Emergency Contact: _____ Phone: _____

Occupation:_____ Full Time or Part Time

List all your allergies: _____

List all prescription medications: _____

List all supplements: _____

1) Have you had any of these health conditions in the past or present? Check all that apply.

Cancer	☐	Headaches (chronic)	☐
Hormone imbalance	☐	Hepatitis	☐
Systemic disease	☐	Herpes	☐
High/Low blood pressure	☐	Frequent cold sores	☐
Spinal injury	☐	Autoimmune disorders	☐
Thyroid condition	☐	HIV/AIDS	☐
Hysterectomy	☐	Lupus	☐
Diabetes	☐	Metal bone pins or plates	☐
Heart problems	☐	Phlebitis, blood clots, poor circulation	☐
Varicose veins	☐	Blood clotting abnormalities	☐
Arthritis	☐	Light sensitivities	☐
Asthma	☐	Wear contacts or glasses	☐
Eczema	☐	Form thick or raised scars from injuries	☐
Epilepsy	☐	Skin disease/lesions	☐
Seizure disorder	☐	Any active infection	☐
Sinus problems	☐	Connective tissue disease	☐
Wear a pacemaker	☐	Experienced claustrophobia	☐
Liver conditions	☐	Any other health conditions?_____	

Explain any checked or other health conditions:_____

_____

2) Answer the following yes or no questions:

Are you pregnant or nursing? Y N Taking oral contraceptives? Y N

Do you have a heart condition? Y N Describe:_____

Are you under the care of a physician or dermatologist for an ongoing condition? Y N

Describe:_____

List any recent surgeries/plastic surgery?_____

Do you smoke? Y N Do you drink alcohol? Y N Weekly consumption?_____

Do you exercise regularly? Y N Daily consumption of: Water_____ Caffeine_____

Do you follow a restricted diet? Y N Describe:_____

Problems sleeping? Y N How many hours a night?_____

What is your level of stress? High Medium Low

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3) Answer the following questions concerning your skin.

Do you have any tatoos, piercings or permanent cosmetics? Y N

Had previous facial treatments? Y N Describe:_____

Do you use Retin-A, Accutane, or other topical vit. A derivative? Y N

Do you use medications that cause light sensitivity? Y N

Do you have any open wounds? Y N Describe:_____

Have you used an acne medication? Y N When?_____ Which drug?_____

Do you have Hyperpigmentation (darkening of the skin)? Y N

Do you have Hypopigmentation (lightening of the skin)? Y N

Have you used a tanning bed in the last 48 hours? Y N

How frequently are you exposed to the sun or use a tanning bed? Reg_____ Frequ_____ Infrequ_____

Have you had any previous facial treatments? Y N Describe:_____

Have you ever had an adverse reaction after using any skin care product? (Circle all that apply.)

Rash Irritation Peeling Breakout Sun Sensitivity

Have you ever had an allergic reaction to any of the following? (Circle all that apply.)

Food Cosmetics Pollen Latex AHA's Iodine Medicine Shellfish

Animals Fragrance Sunscreen Other:_____

If circled, please explain:_____

Any menopause problems? Y N Explain:_____

I confirm that the information that I have provided above is true, complete and accurate and that I have not withheld or otherwise omitted, whether in whole or in part, any information concerning my health status. I 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 aesthetician (skin care professional) of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof. I confirm that the procedures I elect have been explained to me, that I have had the oppurtunity to ask questions related to the procedures, that I have been provided with the answers to such questions and that I understand the importance of strictly following the post-treatment care instructions as explained to me verbally and in the materials provided to me.

Client Name (printed) _____

Client Name (signature) _____ Date _____

Aesthetician (signature) _____ Date _____

Aesthetician Notes

_____

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