

Client Information and Health History

To provide you with the most appropriate treatment, completion of the following questionnaire will assist the esthetician. All information is confidential.

Medical History: Are you currently under the care of a medical or health care professional? Yes No

History	Comments	
	Yes	No
Medical		
Pregnant/ Planning		
Pacemaker		
Metal Implants		
Diabetes		
Herpes Simplex		
Migraines		
Autoimmune		
Cancer current/ recovered		
Radiation in past 3month		
Chemotherapy in past 3month		
Epilepsy		
Blood Pressure Issues		
Circulatory Disorders		
Varicose Veins		
Heart Conditions		
Embolism/Thrombosis		
Bruise Easily		
Edema		
Undiagnosed Swelling		
Loss of Tactile Sensation		
Arthritis /Osteoporosis		
Broken Bones/Strains		
Recent Surgery		
Mobility Issues		
Anxiety/Depression		
Claustrophobia		
Vertigo		
Asthma		
Thyroid Issues		
Gynecological Issues		
Menopausal Symptoms		
Digestive Disorders		
Hepatitis		
Skin Disorders		
Allergies	Yes	No
Sun Reaction		

Medication			
Environmental			
Food			
Latex			
Aspirin			
Cosmetic Ingredients			
Other not mentioned			
Nutrition			
Do you have a regular eating schedule?			
Do you follow a balanced diet?			
Do you add additional salt or sugar			
Do you eat Fast Food?			
Daily water consumption			
Daily caffeine consumption			
Lifestyle			
Stress levels	1	2	3 4 5 6 7 8 9 10
Sleep Pattern	Good	Poor	Restless # Hours of uninterrupted sleep
Physical Activity Level	Walk	Swim	Cardio Resistance Training Team Sport Sedentary
Skin Specifics			
	Yes	No	
Recent microblading			Date: Comments:
Recent permanent makeup			Date: Comments:
Recent Laser			Date: Comments:
Hair Removal			Date: Comments:
Botox			Date: Comments:
Fillers			Date: Comments:
Chemical Peel			Date: Comments:
Sun/tanning bed exposure			Date: Comments:

I certify that the information I have provided is current and correct. I am aware that it is my responsibility to inform the esthetician of any changes to medications or medical conditions. I understand the treatment procedures and any possible reactions that could occur. I hereby give my consent to receive the treatment.

Client Signature: _____ Date: _____