Bodyworks Massage Center and Gift & Wellness Shop

Confidential Client Health History: Facials / Skin Care

Please print or write clearly. Thank you!

Today's Date: _____

Last Name First Name Middle Initial

Mailing Address City State ZIP

Email Address ❑ Transaction emails only. ❑ Include seasonal updates

❑ Home Phone ❑ Mobile Phone ❑ Receive Text Notifications? ❑ Work Phone

Please indicate (☑) your preferred contact number for appointment reminders or schedule changes, etc.

Date of Birth Age* | *Signed parental consent required if under 18. ❑ Male ❑ Female Marital Status

Occupation Employer

How did you hear about us? ❑ Gift Certificate ❑ Drive By ❑ Social Media: _____ ❑ Other: _____

EMERGENCY CONTACT: _____

Name / Relationship Telephone

Do any of the following apply to you today?

❑ Cold sores or fever blisters
❑ Cold or flu symptoms or fever
❑ Headache / migraine
❑ Incontinence (Bladder, bowel)
❑ Inflammation
❑ Irritated skin, rash
❑ Open cuts, bruises, burns
❑ Pain medication
❑ Severe pain
❑ Sunburn
❑ Wearing contact lenses
❑ Wearing dentures or hearing aids

Which of the following best describes your skin type?

❑ Sensitive ❑ Dry ❑ Combination ❑ Oily ❑ Very oily / large pores ❑ Oily in T-zone, dry to normal cheeks

Do you have any concerns about your skin?

❑ Acne management ❑ Acne scarring ❑ Age management ❑ Age spots ❑ Broken capillaries ❑ Enlarged pores
❑ Fine lines & wrinkles ❑ Pigmentation ❑ Scarring ❑ Sun damage ❑ Relaxation / Rejuvenation ❑ Other

Do you have any allergies or sensitivities?

❑ NO ❑ YES, explain_____

HEALTH HISTORY OVERVIEW

1. Have you been under the care of a physician, dermatologist or other medical professional within the past year?

   ❑ NO ❑ YES, explain: _____

2. Have you had any recent injections (Botox, fillers, etc.) or surgery, including plastic surgery?

   ❑ NO ❑ YES, explain: _____

3. Have you ever had skin cancer?

   ❑ NO ❑ YES, explain: _____

4. Do you have any piercings, tattoos, or permanent cosmetics?

   ❑ NO ❑ YES, explain_____

5. Have you ever had a facial or body spa treatment before?

   ❑ NO ❑ YES, When? _____

6. Are you pregnant or nursing? ❑ NO ❑ YES: Due / Delivery date: _____

   Prenatal caregiver / physician: _____

7. List any prescription medications you take regularly:

   _____

   _____

8. List any over the counter medications you take regularly: (vitamins, supplements, aspirin, etc.):

   _____

   _____

9. Do you use Retin-A, Renova, Adapalene, Differin, Tretinoin, Glycolic Acid, AHA, Salicylic Acid or Retinol/Vitamin A derivative products?

   ❑ NO ❑ YES, explain: _____

10. Have you used any of the above products in the last three months?

    ❑ NO ❑ YES, explain: _____

11. Have you used an acne medication?

    ❑ NO ❑ YES, explain: _____

12. Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma?

    ❑ NO ❑ YES, explain: _____

13. Have you been exposed to the sun or used a tanning bed in the last 48 hours?

    ❑ NO ❑ YES, explain: _____

14. Do you have any metal implants or wear a pacemaker?

    ❑ NO ❑ YES, explain? _____

15. Have you ever experienced claustrophobia?

    ❑ NO ❑ YES, explain: _____

16. Have you ever had an adverse reaction after using any skin care product?

    ❑ Rash ❑ Irritation ❑ Peeling ❑ Sun sensitivity ❑ Breakout ❑ Other: _____

PLEASES INDICATE YOUR CONSUMPTION LEVEL:

	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑
Physical Activity	❑	❑	❑	❑
Stress	❑	❑	❑	❑
Sun Exposure	❑	❑	❑	❑
Tanning Bed	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Water	❑	❑	❑	❑

DO YOU NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING HEALTH CONDITIONS?

- ❑ Arthritis
- ❑ Asthma
- ❑ Blood clotting abnormalities
- ❑ Cancer
- ❑ Diabetes
- ❑ Eczema
- ❑ Epilepsy
- ❑ Fever blisters
- ❑ Frequent cold sores
- ❑ Headaches (chronic)
- ❑ Heart problem
- ❑ Hepatitis
- ❑ Herpes
- ❑ High blood pressure
- ❑ HIV/AIDS
- ❑ Hormone imbalance
- ❑ Hysterectomy
- ❑ Insomnia
- ❑ Keloid scarring
- ❑ Lupus
- ❑ Metal bone pins or plates
- ❑ MRSA
- ❑ Neck pain
- ❑ Phlebitis, blood clots, poor circulation
- ❑ Psychological treatment
- ❑ Rosacea
- ❑ Seizure disorder
- ❑ Skin disease / skin lesions
- ❑ Spinal injury
- ❑ Staph infection
- ❑ Systemic disease
- ❑ Telangiectasia / Couperose
- ❑ Thyroid condition
- ❑ TB
- ❑ Varicose veins
- ❑ Other:

PLEASE READ THE FOLLOWING AND SIGN BELOW

I understand, have read and completed this questionnaire truthfully. ● I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. ● 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 esthetician / skin care therapist of my current medical or health conditions and to update this history. ● I understand that this treatment is not a substitute for medical care and that no diagnosis will be made. ● The treatments I receive here are voluntary and I release Bodyworks Massage Center Inc. from liability and assume full responsibility thereof. ● I also understand that payment is due when services are rendered and that I am responsible for paying for any missed appointments or any appointment not cancelled as explained in our APPOINTMENT POLICY contained herein.

_____

Signature Date

APPOINTMENT POLICY

We require 24 hours' notice to cancel or reschedule your appointment. ● Failure to honor this policy will result in a **LATE CANCELLATION FEE OF 50%** of the value of your service. ● Neglecting to call us to cancel an appointment will result in a **NO-SHOW FEE OF 100%** of the value of your service. ● Exceptions will be made for emergencies and inclement weather. ● We reserve the right to require credit card or gift certificate information to hold your appointment.