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		
Medical	**Yes**	**No**	
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: _____