Escape WELLNESS SPA
EscapeAndFeelBetter.com

Name: _____

Address: _____

City/State/Zip Code: _____

Phone: _____ Occupation_____

Email: _____

Date of Birth: _____ - _____ - _____

1. What is the reason for your visit today?

_____

2. What special areas of concern do you have?

Pigmentation Age Spots Fine Lines/Wrinkles Sun Damage Scars Hair Removal Acne Other: _____

3. Do you? Sunbathe Use a tanning bed

How often? _____

4. Have you ever had:

Microdermabrasion Cosmetic surgery Laser hair removal Cosmetic fillers Collagen injections Chemical or natural peels Botox IPL Laser treatments

How recently? _____

5. Do you bruise easily? Yes No

6. Do you get cold sores/blisters? Yes No

7. What medications/hormone replacements/vitamins do you take?

_____

8. Have you ever used: Accutane Retin-A Renova Topical Antibiotic Hydroquinone

9. Personal or family history of cancer? Yes No

_____

10. Are you under the care of a physician? Yes No

If yes, please explain: _____

11. Have you ever had a reaction to:

Metals Medication Food Cosmetics Fragrance Airborne particles

Other allergies (milk, citrus, aspirin, latex, topical creams)

If yes, what: _____

12. Do you wear contact lenses? Yes No

13. Do you experience breakouts? Yes No

14. Do you have ingrown hairs? Yes No

15. FOR WOMEN

Are you on birth control? Yes No

Are you pregnant? Yes No

16. How would you describe your overall health?

Excellent Good Fair Poor

17. Have you had any of the following, past or present?

Acne Yes No

If yes, when: _____

Allergies Yes No

Arthritis or Bursitis Yes No

Irregular Blood Pressure Yes No

Cataracts Yes No

High Cholesterol Yes No

Claustrophobia Yes No

Diabetes Yes No

Diarrhea/Constipation Yes No

Eczema/Psoriasis Yes No

If yes, where: _____

Epilepsy Yes No

Headaches Yes No

How often: _____

Heart Problems Yes No

If yes, what: _____

Hepatitis Yes No

Hirsutism Yes No

HIV Yes No

Hormone Imbalance Yes No

Infections Yes No

Lupus Yes No

Metal Implants Yes No

Pace Maker Yes No

Phlebitis Yes No

Serious Injury Yes No

If yes, what: _____

Thyroid Yes No

18. Do you normally sleep well? Yes No

19. Do you smoke? Yes No

20. Do you regularly exercise? Yes No

21. Do you follow any special diet/have food intolerances? Yes No

If yes, explain: _____

22. What is your level of stress? High Med Low

23. Daily water intake? _____ glasses a day

24. How many cups of caffeine-type beverages (coffee, tea, soft drinks) do you consume daily? None 1-3 cups 4 or more

25. How would you describe your skin?

Oily T-zone/Combination Sensitive Normal Dry

26. Are you interested in upgrading your facial today? Yes No

Informed Release

I do fully understand all the questions above and have answered them correctly and honestly. I understand that the services offered are not substitute for medical care. I understand that the practitioner will completely inform me of what to expect in the course of treatment, and will recommend adjustments to my regimen if deemed necessary.

I release the therapist and the staff harmless from any liability that may result from this treatment. I am responsible for paying for any appointment cancellations of less than 24 hours' notice.

Signature/Date: _____

Referred By: _____