

### 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
<b>Medical</b>	<b>Yes</b>	<b>No</b>
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		
<b>Allergies</b>	<b>Yes</b>	<b>No</b>
Sun Reaction		
Medication		

Environmental			
Food			
Latex			
Aspirin			
Cosmetic Ingredients			
Other not mentioned			
<b>Nutrition</b>			
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			
<b>Lifestyle</b>			
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
<b>Skin Specifics</b>			
	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: \_\_\_\_\_