CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name ______________________________ Today's Date ______________

Date of Birth______________________ Age______ Occupation____________________________

Home Address______________________________ City______________ State_____ Zip Code________

Home Phone______________________________ Work Phone__________________________

Emergency Contact Name ______________________________ Phone__________________

How were you referred to us? ____

Do you regularly sun bathe or use tanning salons? ___________ How often? ____________________

E-Mail ____

MEDICAL HISTORY

Are you currently under the care of a physician? ❑Yes ❑ No

If yes, for what: ____

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Do you have any of the following medical conditions? (Please check all that apply)

❑Cancer ❑Diabetes ❑High blood pressure ❑Herpes ❑Arthritis

❑Frequent cold sores ❑HIV/AIDS ❑Keloid scarring ❑Skin disease/Skin lesions

❑Seizure disorder ❑Hepatitis ❑Hormone imbalance ❑Thyroid imbalance

❑Blood clotting abnormalities ❑Any active infection

Do you have any other health problems or medical conditions? Please list: ____________________________

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Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) ❑Food ❑Animal Protein ❑Aspirin ❑Lidocaine ❑Hydrocortisone

❑Hydroquinone or skin bleaching agents ❑Others: ____

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