



CLIENT INFORMATION & MEDICAL HISTORY FORM

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

Name _____ Today's Date _____

Date of Birth _____ Age _____ Sex: M F

Home Address _____ City _____

State _____ Zip Code _____ Email _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ ext. _____

Emergency Contact Name _____ Phone (____) _____ - _____

Relationship to you _____

How were you referred to us? _____

Which of the following best describes your skin type? (Please circle one type number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

MEDICAL HISTORY

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

If yes, for what:

Are you currently under the care of a dermatologist? Yes No

If yes, for what:



Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No

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

- Arthritis Blood clotting abnormalities High blood pressure Cancer Diabetes
- Cardiovascular conditions Frequent cold sores Hepatitis HIV/AIDS
- Hormone imbalance Any active infection Keloid scarring Thyroid imbalance
- Seizure disorder/Epilepsy Skin disease/Skin lesions Other health problems/conditions

Please describe:

Do you have any allergies?

(Please check all that apply and describe the reaction you experienced)

- Food Latex Essential Oils/Fragrances Medications/supplements:

MEDICATION

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What oral medications are you presently taking?

- Mood altering or anti-depression Birth control pills Hormones
- Herbal supplements Others (Please list):

Are you currently taking Accutane (Isotretinoin)? Yes No

What topical medications or creams are you currently using? Retin-A® Others (Please list):

For our female clients: Are you pregnant or trying to become pregnant? Yes No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the therapy technician of my current medical or health conditions and to update this history as needed. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date _____