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 and Phone_____

How were you referred to us? _____

Do you regularly sun bathe or use tanning salons?_____How often?_____

MEDICAL HISTORY

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

If yes, for what:_____

_____

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 ❑Myesthenia Gravis

❑Eye Disease/Vision Problems ❑Autoimmune Disease ❑Multiple Sclerosis

❑Amyotrophic Lateral Sclerosis (ALS) ❑Parkinson's Disease ❑Lambert-Eaton Syndrome

❑Neurological Disorders/Numbness/Weakness ❑Lupus

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

_____

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**:**_____

_____

_____

MEDICATIONS

What oral prescription medications are you presently taking? ❑Birth control pills ❑Hormones

❑Others (It is required that you list all of them): _____

_____

What antibiotics do you use to treat infections?_____

_____

Do you take any medications for heart conditions? _____

_____

Are you on any mood altering or anti-depression medication?_____

What topical medications or creams are you currently using? ❑ RetinA , ❑Others (Please list):

_____

What herbal supplements do you use regularly?_____

HISTORY

<u>For our female clients:</u>

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No

Are you using contraception? ❑Yes ❑No

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

Signature_____ Date:_____