Skin Health
MEDI-SPA

Skin Health LLC client consultation card

Name_____D.O.B_____
Address_____City_____State_____Zip_____
Phone/Home_____ Cell_____
Would you like to receive text reminders? YES___ NO___
E-Mail address_____
How did you hear about us?_____
Who referred you? (for our referral program)_____
Are you currently a patient of Dermatology and Skin Health?_____
Allergies you might have_____
Please list any current prescription, over the counter medications, or supplements you are currently taking_____
Are you, or could you be, currently pregnant? YES NO. If so, how many months?_____
Are you currently nursing? YES NO

Please put an X next to all that apply:

Have you ever had any of the following...

Arthritis	_____	HIV/Hepatitis	_____	Spinal Injury	_____
Autoimmune Disorder	_____	Hormone Imbalance	_____	Systemic Disease	_____
Cancer	_____	Recent Surgery	_____	Thyroid Condition	_____
Diabetes	_____	Severe Back Pain	_____	Varicose Veins	_____
Epilepsy/Seizures	_____	Skin Infections	_____	Vertigo	_____
Heart Disease	_____	Skin Conditions (Eczema, Psoriasis, Etc.)	____		

Do You...

Anxiety Disorder	_____	Have a Metal Implant	____	Smoke	____
Claustrophobic	_____	Have a Pacemaker	____	Suntan/Tanning beds	____
Exercise Regularly	_____	Sensitive to touch or Pressure	____	Wear Contacts Lenses	____
Have High/Low Blood Pressure (circle one)					

Have you recently had any of the following:

___ Botox or filler *If yes, when was the last treatment date? _____
___ Chemical peel, laser/IPL treatment, microneedling, or other. * If yes, when was the last treatment date? _____
___ Cosmetic surgery *If yes, when? _____ Where? _____

Do you currently use / have you used in the past: (please circle)
Accutane, Retin A, Renova, Avage, Differin, Tazorac, or other chemical exfoliant?
If you have answered YES to any of the above, please explain:

_____
_____

Skin care products you're currently using:

_____
_____

What are your goals for today's treatment

_____

Are you interested in learning about other treatments we or Dermatology and Skin Health offers? YES NO

Please see other side →

WAIVER AGREEMENT CONTRACT

I hereby consent Skin Health LLC to perform discussed treatment(s) procedure(s) on me and in consideration of their doing so I hereby release and forever discharge Skin Health LLC from all claims, demands damages action or cause of action arising out of the performance of discussed treatment(s). I confirm that I have completed the above information and certify that I do not have any other health conditions or allergies.

Please initial each line below:

General spa services:

_____ I understand that Skin Health spa treatments are for relaxation and wellness purposes. Results may vary and no guarantees are made.

Medical aesthetic services:

_____ I acknowledge that certain treatments involve risks such as but not limited to bruising, swelling, or temporary sensitivity. I have disclosed my full medical history and understand the potential risks.

Skin sensitivity & allergies:

_____ I have informed Skin Health of any allergies or sensitivities. I release Skin Health from liability related to allergic reactions.

Massage Services:

_____ I understand that massage therapy has therapeutic properties but is not a substitute for medical treatments.

Hair & chemical services:

_____ I acknowledge that color and chemical treatments carry risks and results may vary based on the condition of my hair.

Cancellation policy:

_____ I understand that canceling my appointment without a 24 hour notice (72 hours for coolsculpting) or a no-show will result in a charge of 50% of the service fee.

I confirm that the information provided is accurate to the best of my knowledge. I understand the risks and benefits of the services I receive.

Signature_____Date_____

Parent or Guardians Signature (under the age of 16 or 18 for medical services)_____