Natural Health Practices
4904 Clyde Morris Blvd. Suite A | Port Orange, FL 32129 | 386-307-8207

HEALTH QUESTIONNAIRE AND CONSENT FOR NEW SKIN CARE CLIENTS

Full Name:	Today's Date:
Mailing Address:	Date of Birth:
City and State:	Zip:
Email Address:	Cell Phone:
Preferred primary method of contact (circle one): Email Phone Call Text Message	Whom may we thank for referring you to us?

1. Please list the main concerns that you have with your skin and what you would like to achieve from your treatment:

_____

_____

2. Which skincare and cosmetic products are you currently using? (List brand if known.)

_____

_____

3. Have you ever had a facial treatment before? □ No □ Yes If yes, when and what was the last treatment performed?

_____

_____

4. Any recent surgeries, including plastic surgery? □ No □ Yes If yes, please explain: _____

5. Have you ever experienced an allergic reaction to any of the following? (please check any that apply.)

□ Cosmetics □ Medicine □ Food □ Sunscreens
□ Fragrance □ Shellfish □ Latex □ Iodine
□ AHAs □ Other: _____

6. Have you ever had chemical peels, laser, or microdermabrasion? □ No □ Yes In the last month? □ No □ Yes

7. Do you use or have you ever used Adapalene Hydroxy Acid/Differin/Epiduo, Alpha Hydroxy Acid (glycolic or lactic acid), Beta Hydroxy Acid (salicylic acid), Accutane, Retin-A/Tretinoin/Renova or any other vitamin A derivative product? □ No □ Yes
In the last three months? □ No □ Yes If yes, please explain: _____

8. Have you received Botox, Restylane or Collagen Injections? □ No □ Yes
If yes, specify which one and how long ago: _____

9. Have you had any of the following health conditions in the past or present? (This helps determine contraindications to treatments.)

□ Cancer
□ Hormone Imbalance
□ High/Low Blood Pressure
□ Immune Disorders
□ Spinal Injury
□ Diabetes
□ Heart Problem
□ Headaches
□ Hepatitis
□ Fever Blisters/Cold Sores
□ Scar Easily
□ HIV/AIDS
□ Poor Circulation
□ Arthritis
□ Skin Diseases/Skin Lesion
□ Active Infections
□ Epilepsy
□ Eczema
□ Asthma
□ Other: _____

HEALTH QUESTIONNAIRE AND CONSENT FOR NEW SKIN CARE CLIENTS

10. List any medications you are taking regularly (not including wholefood supplements):

_____

_____

11. Have you been exposed to excessive sun or a tanning bed within the last 48 hours? □ No □ Yes

12. Do you tan easily? □ No □ Yes Sunburn easily? □ No □ Yes

13. Have you ever experienced claustrophobia? □ No □ Yes

14. Circle all hair removal methods you have used on your facial skin in the past three weeks:

□ Shaving □ Waxing □ Electrolysis □ Plucking/Tweezing □ Stringing □ Depilatories

Did you have any reaction to these methods? If yes, please explain: _____

15. What areas of concern do you have regarding your skin? (Please check any that apply.)

□ Breakouts/Acne
□ Excessive Oil/Shine
□ Rosacea
□ Broken Capillaries
□ Redness/Ruddiness
□ Sun Spots/Liver Spots/Brown Spots
□ Sun Damage
□ Wrinkles/Fne Lines
□ Dull/Dry Skin
□ Flaky Skin
□ Dehydrated
□ Other: _____

Eyes: □ Dehydrated □ Wrinkles □ Puffiness □ Dark Circles □Other: _____

Lips: □ Dehydrated □ Cracked/Chapped Lips □ Other: _____

Female Clients Only:

16. Are you taking any oral contraceptives? □ No □ Yes

17. Are you pregnant or trying to become pregnant? □ No □ Yes

18. Are you experiencing any menopause problems? □ No □ Yes If yes, please specify:_____

PERMISSION AND CONSENT TO SKIN CARE TREATMENT WITH JENNIFER KRUPA AT NATURAL HEALTH PRACTICES

I understand, have read and fully completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. While all treatments are recommended to achieve the best possible results, I do understand that not all treatments will have the same results on every client, therefore no guarantee can be given. I also understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the Esthetician of my current medical or health conditions and to update this history. The treatments I receive today and any subsequent visit are voluntary, so I release Natural Health Practices Inc and my Esthetician, Jennifer Krupa, from liability and I assume full responsibility thereof.

Client Signature: _____ Today's Date: _____

CONSENT TO FUTURE PROMOTIONS

May we contact you via email/mail about future skin care promotions? □ No □ Yes