BackBone

WELLNESS CENTER

Confidential Client Information

Name____

Street Address____

City_____________________Zip_________Phone____________________Alt/Cell________________________

Email ____DOB________________What is your age? _____

How may we contact you? Email ☐ Text ☐ Cell Phone Provider ___________________Telephone ☐

What is your family background (ethnicities; some skin is more sensitive than others)? ______________________

How did you hear about Flourish Wellness Spa? ____

Would you like to receive our Newsletter & promotional emails? Yes No

Medical History

Are you in **good health**? Yes ☐ No ☐

Do you have a **history of cold sores**?____

Do you have any **allergies? (Latex, aspirin, shellfish, etc.) Please list any allergies**_____________________________

____

Do you take **any medication**(s)? If yes, please list ____

Do you take **regular vitamins/herbs**? If yes, please list ____

Any **recent surgeries**? If yes, please include date & type ____

Any complications? ____

Any **serious illnesses or** disease? If yes, please list ____

Does your **diet include** (Please circle) Dairy ☐ Fruit ☐ Soy ☐ Wheat ☐ Sugar ☐

What is your daily **liquid intake**? (In cups) Water______Coffee______Tea______Soda______

How often do you drink **alcoholic beverages**? ________________

Do you use **tobacco products**? ___________

Do you take **birth control pills or hormones**? If yes, what type? ____

Are you **pregnant, trying to become pregnant or lactating**? ____

Do you **currently take Accutane** or have taken in the past? If yes, please include dates________________________

Skin Care History & Analysis

What best **describes your skin**? (Please circle) Oily ☐ Normal ☐ Dry ☐ Combination ☐ Sensitive ☐

Which of the following would you **like to improve**? (Please circle)

Acne ☐ Scarring ☐ Pigmentation Problems ☐ Pimples ☐ Blackheads ☐ Clogged Pores ☐ Enlarged Pores ☐ Wrinkles/Aging ☐

Do you **currently use, or have used in the past**, any of the following on your face? (Please circle)

Chemical Peels☐ Microdermabrasion☐ Wax☐ Scrubs☐ Buff/Loofah☐ Clarisonic☐ Electrolysis☐ Laser/IPL☐

Retin-A (tretinoin)☐ Benzoyl Peroxide☐ Hydroquinone☐ Glycolic Acid☐ Salicylic Acid☐

What **brand/type of skin care products** are you currently using? ____

____

Do you **sunburn easily**? Yes ☐ No ☐ Do you **tan easily**? Yes ☐ No ☐ Do you use a **tanning bed**? Yes ☐ No ☐

Any **history of skin cancer/any malignancies**? If yes, please include type/dates_____________________________

What are your **skin care goals**?____

____

These questions are relevant to your skin health in regards to microcurrent, which I may use in facial treatments and may be contraindications for treatment. Please answer thoroughly

Question	Y	N	Details If Applicable	Adverse Reactions If Applicable
Are you pregnant or nursing?				
Do you have any active cancer?				
Do you have any metal implants, including plates, screws or pins?				
Do you use a pacemaker?				
Do you have heart problems?				
Do you have high blood pressure?				
Do you have braces, metal fillings or other dental implants?				
Do you currently have a cold or flu?				
Do you have an autoimmune disorder (including HIV) or connective tissue disease?				
Do you use Retin-A, Accutane or any other prescribed topical vitamin A derivative?				
Have you ever had Botox, Juvederm or any other injectable?				

Have you ever had any of these conditions? (Please check)

__Melanoma __Migraines __Open wounds __Sensitive skin __Stroke/TIA __Skin inflammation __Thyroid conditions

Any other health conditions not listed? ____

____

Is there anything else we should know about? ____

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your microcurrent treatment, please be aware of the following information and possible risks.

Please initial:

___I understand that the use of Botox, Juvederm, Restylene and any other injectable must be disclosed prior treatment.

___I understand that microcurrent treatments involve conducting mild electrical currents through the body and this brings some inherent risk.

___I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

___I understand that some clients report slight tingling sensations, flashing of the optic nerve, and/or metallic taste in the mouth during the procedure.

___I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

___I understand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.

___I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

___I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

___I consent to “before and after” photographs for the purpose of documentation, potential advertising and promotional purposes.

I understand that there are certain risks associated with facial services. I understand that if I have any concerns, I will address these with my skin care specialist. I give permission to my skin care specialist to perform the procedure we have discussed and will hold Flourish Wellness Spa and TAMA Research, Inc., harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the skin care specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of the procedure, which may be affected by the treatment performed today.

Client Name (Printed) ________________________________(Signature)________________________

Skin Care Specialist Name ____ Date _________