COPPER TREE RETREAT
MASSAGE•MEDSPA

Confidential Client Health History Form

Name: _____ Date:_____

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year? □ No □ Yes, explain: _____

2) Have you had any surgeries, including plastic surgery? □ No □ Yes, explain: _____

_____

3) Have you ever had □ Botox, □ fillers, or □ facial lasers? If so, when? _____

4) List any medications (including prescription skin care products, acne medication, birth control, etc.) you take regularly:_____

5) List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:_____

6) List any known drug allergies:_____

7) Have you ever had any of these health conditions in the past or present? (Please check all that apply and provide additional information in the space provided)

Cancer _____(type)

□ Headaches (chronic)	□Hormone imbalance	□ Hepatitis
□High blood pressure	□ Fever blisters/Cold sores	□Spinal injury
□ Immune disorders	□Thyroid condition	□ HIV/AIDS
□Thyroid condition	□ Metal bone pins or plates	□Diabetes
□ Blood clotting abnormalities	□Heart problem	□ Psychological treatment
□Arthritis	□ Skin diseases/skin cancer _____(type)	
□Asthma/Breathing problems	□ Any active infection	□Keloid scarring
□ Any eye problems	□Seizure disorder	

8) Do you smoke? □ No □ Yes

9) Do you drink alcohol? □ No □ Yes If yes, how much do you drink? _____/day _____/week

10) Have you ever had an allergic reaction to any of the following?

(Please check all that apply and provide additional information in the space provided)

Cosmetics □ Medicine □ Skin Care Products □

Latex □ Fragrance □ Iodine □

Sunscreens □ AHAs (alpha-hydroxy acids) □ Food □

Drugs □ Shellfish □ Pollen □

Animals □

Other: _____

If yes, please explain:_____

11) Do you form thick or raised scars from cuts or burns? □ No □ Yes

12) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? □ No □ Yes, describe: _____

13) How often are you exposed to the sun or use a tanning bed? Y/N Infrequently _____

Frequently _____ Regularly_____

14) What SPF do you use on your face? _____ How often/when?_____

15) Have you recently used any self-tanning lotions, creams or treatments? □ No □ Yes, specify:_____

16) Have you used any of the following hair removal methods in the past six weeks? □ No □ Yes

Shaving □ Electrolysis □ Waxing □ Stringing □ Plucking □

Depilatories □ Tweezing □

17) Have you ever had a body spa treatment before? □ No □ Yes, when: _____

18) What skin care products are you currently using? (List brand where known)

Soap _____ Shower Gels _____

Toner _____ Body Lotions _____

Mask _____ Sunscreen _____

Eye Product _____ Night Moisturizer/Cream _____

Cleanser _____ Day Moisturizer _____

Exfoliator _____ Scrubs _____

Makeup Products _____

Other _____

19) What areas of concern do you have regarding your: (Please check any that apply)

Skin:

Breakouts/acne □ Uneven skin tone □ Blackheads/whiteheads □

Sun damage □ Excessive oil/shine □ Wrinkles/fine lines □

Rosacea □ Dull/dry skin □ Broken capillaries/redness □

Flaky skin □ Sun spot/liver spot/brown spot □

Dehydrated □ Thin eyelashes □

Eyes:

Dehydrated □ Wrinkles □ Puffiness □ Dark circles □ None □

Other:_____

Lips:

Dehydrated □ Cracked/chapped lips □ None □ Other: _____

20) I would like to know more about:

Please check all that apply:

□ Eyelash length, fullness, thickness, or darkness

□ BOTOX® Cosmetic/Dysport for wrinkles

□ Facial Fillers (Restylane, Juvederm, Perlane, Radiesse)

□ Cosmetic Eyelid surgery

□ Laser Skin Resurfacing or other treatments

□ Skin care products/advice

□ Thin lips

□ Facial veins

□ Facial redness

□ Liver spots/age spots

□ Birthmark

□ Blotchy skin

□ Drooping eyelids

□ _____

Female Clients Only:

21) Are you taking oral contraceptives? □ No □ Yes, specify: _____

22) Are you pregnant or trying to become pregnant? □ No □ Yes

23) Are you breast feeding? □ No □ Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I 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 aesthetician/doctor of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature :_____ Date: _____

Technician Signature : _____ Date: _____

Doctors Signature: _____ Date: _____