Piper Rose Spa

CONFIDENTIAL HEALTH HISTORY

Todays Date:_____

NAME_____

PERSONAL INFORMATION

Birthdate:_____ / _____ / _____ (for birthday gift)

Address:_____City_____ State_____ Zip_____

Cell Phone:_____ Alt.Phone:_____

* Cell Phone Provider_____ (Cell phone provider needed for text reminders)

Appointment Scheduling Preference: M T W Th F S AM / PM

Email:_____

Physician:_____ Physician phone #:_____

Emergency Contact Name & Phone #:_____

Occupation:_____

HEALTH INFORMATION

Currently under a physician, dermatologist, other MEDICAL PROFESSIONALS CARE (excluding routine checkups)

No_____ Yes_____ Please explain:_____

ALLERGIC / ADVERSE REACTION: to any of the following?

Latex _____ Medications_____ Skin Care Products_____ Foods_____ Iodine____ Fragrance_____

Animals/Pollens_____ Other_____ **Asprin Allergy Y_____ N_____**

****Please explain and inform your Aesthetician of ALL allergies_____**

HEALTH CONCERNS

Do you have/had any of the following HEALTH CONDITIONS? (Check all that apply & provide additional information to your Aeshtetican)

	Cancer		Blood Thinners / Bleeding Abnormalities
	Hepatitis		Phlebitis, Blood Clots, Poor Circulation
	HIV / AIDS		High Blood Pressure / Heart Conditions
	Fever Blister / Herpes / Cold Sores		Immune Disorders
	MRSA		Lupus
	Diabetes		Hormone Imbalance
	Hives / Histamine Reactions		Thyroid Condition
	Joint, Spine, Neck, Hand Pain / Injury		Systemic Disease
	TMJ / Jaw concens		Seizure Disorder
	Arthritits / Inflamation		Psychological Treatment
	Sore muscles / Injury's / Nerve Damage		Asthma
	Pacemaker/ Metal Pins or Implants		Any Active Infection

MEDICATIONS

List all Prescription & Over the Counter: _____

(Certain Medications can affect Treatments and/or Products)

SKIN CONCERNS

	Keloid Scarring / Raised Scarring		**Acne (ACUTANE USE: No____ Yes_**
	Mild Scarring		Wrinkles, Fine Lines, Collegan
	Pigment- Hypo (lightening)/ Hyper(darkening)		Enlarged pores

	Skin Lesions / Disease		Unwanted & or Excessive Hair
	Ingrown Hairs		Other:

How often to you wear sunscreen? Everyday____ Occasionally_____ Only when I'm outside_____ Rarely_____

If you go in the sun without sunscreen, how often will you burn?

Always___ Most of time___ Sometimes____Rarely Burn___ Very Rarely ____ Never Burn___

Use of Tanning Beds, spray tans, self tanning lotions or tanning outside:

Daily_____ Once a Week _____ Occasionally_____ Never_____

Ethnic Background _____

Current Skin Care Products You Use : _____

_____

FEMALE CLIENTS

Are you pregnant or trying to become pregnant: N____ Y____ Are you lactating? N____ Y_____

Are you taking oral contraceptives? N____ Y_____ Menapause Concerns?_____

PREVIOUS SKIN CARE TREATENTS

Botox/Fillers____ Waxing____ Microneedling____ Midcrodermabrasion_____ Chemical Peel_____

Permanant Makeup_____ Tattoos_____ Other_____

****Within the last year have you used any form of products containing:**
Retin-A's, Retinol, Trentinoine, AHA's, Glycolic, Salicylic, Benzoyl N____ Y____

I understand and have read and completed this questionaire truthfully. I agree that this constitutes full disclosure and that it supersedes any previous verbal or writtten disclosures. I understand that withholding information or providing misinformation may result in contraindications and or irritation to the skin from treatments recieved. I am aware that it is my responsibility to inform the aeshtetician /skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Piper Rose Spa and or Skin Care Professional from liability and assume full responsibility thereof.

Client Signature:_____ Date:_____

Parent Signature if Minor:_____ Date:_____

Skin Care Professional:_____ Date:_____

Piper Rose Spa

CLIENT INFORMED CONSENT TO TREATMENT

I,_____(print name), consent to and authorize Piper Rose Spa to perform laser, photo facial, skin exfoliation, micro-needling, microdermabrasion, lashes, permanent makeup, skin waxing, Botox, chemical peels, facial and body treatments and /or any other related skin care services.

Please initial the following:

_____ I have not used Retin-A, Retinol A or glycolic peels in the last 72 hours, or Accutane for 12 months.

_____ I have not had pigment changing sun exposure , used a tanning bed with the past 4 weeks, or a spray tan in the past 2 weeks. I will inform the Aesthetician before every treatment if exposed to any of these .

_____ I am not pregnant, epileptic, or have a heart condition or pacemaker.

_____ I understand that eye injury due to the use of laser, or Intense Pulsed Light, is a risk. This risk is reduced with the use of proper eye protection, which will be provided to me.

_____ I have provided accurate information regarding my medical history and prescription drugs and products that I am currently ingesting or using topically. I will immediately update my records as changes occur, including pregnancy, medications, or other medical concerns as I become aware of them.

_____ Possible side effects include, but are not limited to : mild redness, extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, bumpy appearance, and cold sores. Most side effects are temporary and generally fade within a few days.

_____ I agree to follow all post-care instructions, and will contact the technician immediately if I experience any complications, have concerns or questions regarding the treatment or products.

_____ I am over 18 years of age, or I have a parental consent co-signed below.

_____ I understand that there are no guaranteed results, and that my independent results are dependent on my age, skin, condition, lifestyle and a family history, and that in order to achieve y desired results, I may require additional treatment, at additional cost, to obtain my expected results.

I have read and fully understand this agreement. I understand the procedures and accept the risks. I do not hold the technician, or Piper Rose Spa responsible for any of my conditions that were present, but not disclosed at the time of this treatment, which may be affected by the treatment performed today. Nor do I hold the technician or Piper Rose Spa responsible for any side effects, known or unknown, or conditions occurring as a result of these treatments. I freely assume these risks.

_____ _____

Client Signature Date

_____ _____

Parent Signature (if client is a minor) Date