HAND & STONE® MASSAGE AND FACIAL SPA

ESTHETIC CLIENT HEALTH HISTORY FORM

Last Updated: _____

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information. Notes for your appointment entered by your Esthetician will be available for our other Estheticians in order to ensure you are provided with the appropriate treatment at each appointment.

Name:	Phone #:
Home Address:	Email Address:
Occupation:	Date of Birth:
Emergency Contact (mandatory) Name: Phone#:	Primary Care Physician: Address:
How did you hear about us?	Preferred Method of Communication: ☐ Email ☐ Phone

GENERAL HEALTH

Do you wear contact lenses? ☐ YES ☐ NO | Are you claustrophobic? ☐ YES ☐ NO

Please list any accidents or surgeries in the past 12 months:
(if you have had surgery in the past 12 months)

Do you have? Metal Implants ☐ YES ☐ NO | Pace Maker ☐ YES ☐ NO | Body Piercings ☐ YES ☐ NO

List any medication(s)/supplement(s) you are taking:

Are you currently taking? ☐ Antibiotics ☐ Birth Control ☐ Hormone Replacement ☐ Blood Thinners ☐ N/A

HEALTH HISTORY – *Please check here if none apply* ☐

☐ Arthritis	☐ Facial Warts	☐ Herpes Simplex Virus	☐ MRSA	☐ Citrus Allergy
☐ Rosacea	☐ Sun Burn/Allergy	☐ Eye Infection/Disorder	☐ Smoker	☐ Sulfates/Sulfur Allergy
☐ Lupus/Autoimmune	☐ Headaches	☐ Heart Disease	☐ Diabetes	☐ Sciatica
☐ Soy Allergy	☐ Wheat Allergy	☐ Nut Allergy	☐ Seaweed Allergy	☐ Eczema
☐ Psoriasis	☐ Other			

Have you ever been diagnosed with Cancer? ☐ YES ☐ NO | Are you pregnant or trying to become pregnant? ☐ Yes ☐ NO

Any other medical conditions or concerns we need to know about? ☐ YES ☐ NO ☐ N/A If yes, explain:

ESTHETICS

Are you currently under the care of a Dermatologist? ☐ YES ☐ NO

Do you use any of the following topical products? ☐ Accutane ☐ Retin A/Stiva A ☐ Isotretinion ☐ Adapalene ☐ Differin ☐ Vitamin C ☐ Tretinoin/Avita ☐ Scrub/Peel ☐ N/A

☐ Other prescription topical skin products. Please be specific:

Have you had any of the following in the past 2 weeks? ☐ Chemical Peel ☐ Botox ☐ Microderm ☐ Dermal Filler ☐ Permanent Cosmetics ☐ N/A

☐ Other resurfacing treatments, please be specific:

Any serious side effects? ☐ YES ☐ NO If YES, please specify:

Are you currently using any products that contain the following? ☐ Glycolic Acid ☐ Lactic Acid ☐ Hydroxy Acid ☐ Vitamin A ☐ Vitamin C ☐ N/A

Have you had an allergic reaction to any waxing or skincare products? ☐ YES ☐ NO Explain:

Skin Maintenance

Skin Condition/Type: ☐ Oily/Congested ☐ Dry/Dehydrated ☐ Sensitive/Redness ☐ Acne/Breakouts ☐ Sunburned

Have you been tanning in the last 24 hours? ☐ YES ☐ NO

In the last week have you had? ☐ Waxing ☐ Laser ☐ Electrolysis

Do you use sunscreen? ☐ YES ☐ NO If so, what SPF?

What are your primary skin care goals? ☐ Anti-Aging ☐ Sensitivity ☐ Acne/Breakouts ☐ Brightening/Lightening

Comments:

Products Used – List Brand and Frequency of Use

	Brand	Frequency
☐ Soap/Cleanser		
☐ SPF		
☐ Toner		
☐ Exfoliator		
☐ Masque		
☐ Moisturizer		
☐ Serum		

Please Turn Over

Consent: It is my choice to receive **spa treatments**, including facials, peels, LED, microdermabrasion or hair removal/waxing. I understand that the skin care and hair removal program must be used in accordance with the pre/post care instructions and descriptions given to me by the service provider. I understand that I may experience varying degrees of redness, burning, peeling, itching, etc., especially in the initial stages of the treatment program. These symptoms are often normal and will eventually subside as the skin builds tolerance. I understand that it is necessary to maintain the use of a skin care program over the long term in order to retain the benefits obtained in the early weeks of the treatment program. Because facials should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions accurately. I further understand that I am paying for a treatment and not a result and that there will be no returns, refunds or exchanges for services or products given.

I understand that I may disrobe to my comfort level. Some hair removal services require the Esthetician to touch and treat sensitive areas such as breast tissue, genitals, buttocks and inner thighs. Initial Here: _____

I understand that HAND & STONE MASSAGE AND FACIAL SPA reserves the right to refuse to administer services at their sole discretion. I have read and fully understand this form in its entirety. If at any time there are changes in the information given, or in my condition, I will notify my service provider, and update this form before receiving additional services. I have read and fully understand this form in its entirety. I hereby release the Estheticians, HAND & STONE MASSAGE AND FACIAL SPA and their insurers, and their respective officers, directors, stockholders, successors, employees, franchisor and agents from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving skin care (facials, peels), microdermabrasion, massage or hair removal services.

If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24-hour notice, I agree to pay the missed appointment fee that applies. Initial Here: _____

My signature below affirms that I have read, agree to the foregoing and the information I have provided is accurate and true.

SIGNATURE: _____ **DATE:** _____

Consent to treatment of minor: By my signature below, I authorize HAND & STONE MASSAGE AND FACIAL SPA to administer facial and/or hair removal services to my minor child or dependent (name:_____) as they deem necessary or proper.

SIGNATURE: _____ **DATE:** _____

_____ _____

Esthetician Signature **Date**