

# Bloom Skin Spa inc.

## CLIENT PROFILE

(PLEASE PRINT)

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ NAME: \_\_\_\_\_

SALUTATION: (Mr. / Mrs. / Ms. / Miss / Dr.) GENDER: M / F MINOR: Y / N

BIRTHDAY: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (the year is optional)

ADDRESS: \_\_\_\_\_ APT/CONDO # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ email: \_\_\_\_\_@\_\_\_\_\_

OCCUPATION: \_\_\_\_\_

I wish to receive *Bloom Skin Spa* newsletter and/or internet special notices Y / N

### EMERGENCY CONTACT

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ OR (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### DERMATOLOGIST/PHYSICIAN

NAME: DR. \_\_\_\_\_ PRACTICE: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ circle one: FAMILY / DERM / OTHER

### HOW DID YOU HEAR ABOUT *Bloom Skin Spa*

NEWSPAPER	YELLOW PAGES	MAILER	FLYER
COUPON	MENU	BUSINESS CARD	REFERRAL
WEB LINK	SEARCH ENGINE	INTERNET ADVERTISEMENT	
WORK NEARBY	GIFT CERTIFICATE	OTHER _____	

# Bloom Skin Spa inc.

## HEALTH HISTORY FORM

(PLEASE PRINT)

NAME: \_\_\_\_\_

### REASON FOR APPOINTMENT

- FACIAL/SKIN CARE
- PEEL/EXFOLIATION
- BACK TREATMENT
- BODY WRAP/SCRUB
- BODY BRONZING
- HAIR REMOVAL
- HAND/FOOT TREATMENT
- SPECIALTY (tint, lashes, make-up, etc)

### WHAT ARE YOUR PRIMARY SKINCARE CONCERNS THAT WE CAN ADDRESS TOGETHER

- age spots
- sun damage
- sunburn
- pigmentation
- discoloration
- patches
- uneven skintone
- acne
- acne scarring
- blackheads
- whiteheads
- oiliness
- enlarged pores
- broken capillaries
- rosacea
- sensitivity
- irritation
- tightness
- dryness
- flaking
- ingrown hairs
- fine lines
- wrinkles
- dark eye circles
- puffy eyes
- loss of facial neck firmness
- stretch marks
- cellulite/body
- other \_\_\_\_\_

HAVE YOU EVER HAD THIS SERVICE BEFORE? YES / NO WHERE? \_\_\_\_\_

WHAT WAS YOUR EXPERIENCE?

- excellent
- good
- fair
- poor

HAVE YOU EVER HAD A REACTION TO PERSONAL CARE PRODUCTS? YES / NO

PLEASE LIST \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO

PLEASE LIST \_\_\_\_\_

ARE YOU TAKING MEDICATIONS RIGHT NOW? YES / NO

PLEASE LIST \_\_\_\_\_

ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE FOR ANY CURRENT SKIN CONDITION OR

OTHER PROBLEM? YES / NO EXPLAIN: \_\_\_\_\_

DO YOU HAVE A HISTORY OF ANY OF THESE HEALTH CONDITIONS?

- Acute injury
- Allergies
- Arthritis / Bursitis
- Asthma
- Bleeding problems
- Blood clots
- Cancer
- Cardiac problems
- Cholesterol
- Claustrophobia
- Constipation
- Diabetes
- Diarrhea
- Eczema
- Epilepsy
- Fever blisters
- Headaches (chronic)
- Hepatitis
- Herpes
- High blood pressure
- HIV/AIDS
- Hysterectomy
- Immune disorders
- Implants
- Lupus
- Metal bone, pins or plates
- Pacemaker
- Phlebitis
- Psychological problems
- Radiating pain
- Sinus problems
- Skin diseases or disorders
- Sleep problems
- Spinal problems
- Thyroid problems
- Urinary or kidney problems
- Varicose veins
- Other

PLEASE EXPLAIN OR LIST ANY SIGNIFICANT OTHER PROBLEMS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

ARE YOU PREGNANT, TRYING TO BECOME PREGNANT, OR LACTATING YES / NO

ARE YOU EXPOSED TO CHEMICALS, OILS OR OTHER CAUSIC SUBSTANCES THAT MAY AGGRAVATE YOUR SKIN? YES / NO LIST: \_\_\_\_\_

DO YOU EXPERIENCE HORMONE IMBALANCES? YES / NO

ARE YOU TAKING ANY HORMONE REPLACEMENT MEDICATIONS? YES / NO \_\_\_\_\_

ARE YOU TAKING ORAL CONTRACEPTIVES? YES / NO \_\_\_\_\_

ANY PERSONAL OR FAMILY HISTORY OF SKIN CANCER? YES / NO \_\_\_\_\_

HAVE YOU EVER HAD SURGERY? YES / NO EXPLAIN: \_\_\_\_\_

DO YOU HAVE ANY PHYSICAL INJURIES OR DISABILITIES THAT REQUIRE SPECIAL ATTENTION OR CARE DURING YOUR SERVICE? YES / NO EXPLAIN: \_\_\_\_\_

# *Bloom Skin Spa inc.*

## INFORMED RELEASE

I hereby consent to and authorize *Bloom Skin Spa* to perform skincare and beautification treatments. I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards. Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost. I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately. I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically. I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Patient Signature \_\_\_\_\_

Please print Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Esthetician \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I have read and comply with the POLICIES & PROCEDURES of Bloom Skin Spa \_\_\_\_\_