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 have read the cancellation policy: Initial _____

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 ADVETISMENT	
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?

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